

**Before the  
Federal Communications Commission  
Washington, D.C. 20554**

In the Matter of	)	
	)	
Promoting Telehealth in Rural America	)	WC Docket No. 17-310
	)	

**REPORT AND ORDER**

**Adopted: August 1, 2019**

**Released: August 20, 2019**

By the Commission: Chairman Pai and Commissioners O’Rielly and Carr issuing separate statements;  
Commissioners Rosenworcel and Starks approving in part, dissenting in part, and issuing separate statements.

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## I. INTRODUCTION

1. Nearly 60 million people—roughly 1 out of every 5 Americans—live in a rural area.<sup>1</sup> For these millions of Americans, affordable, quality health care at the local level can be scarce. Geographic isolation, combined with low population densities, make the provision of sustainable local health care in rural areas a challenge; indeed, many rural areas have witnessed an increasing number of local health care facilities closing in recent years. Inadequate local resources and difficulties in recruiting and retaining physicians further complicate local access to quality health care. As a result, millions of rural Americans are forced to travel long distances to obtain medical treatment, at significant time and expense not only for the patient but also for friends and family.<sup>2</sup> Those unable to bear the expense may forgo treatment altogether and risk a personal health care crisis.

2. Telehealth services are one important solution to the challenge of health care access in rural areas by connecting rural patients with general physicians and medical specialists located outside the patients’ communities. The Commission promotes telehealth in rural areas through the Rural Health Care Program (RHC Program or Program), which provides financial support to help rural health care providers obtain broadband and other communications services at discounted rates. These services are in turn used by health care providers to offer telehealth to patients living in and around the communities they serve.

3. As the demand for robust broadband has increased throughout the country, the RHC Program has witnessed a dramatic increase in health care provider participation. Even with the Commission increasing the RHC funding cap last year by more than \$170 million over the prior \$400 million funding cap to account for inflation, demand continues to stress the RHC Program. This creates a challenge for program administration, leading to uncertainty among participants as to the status of their funding requests and complicating the planning of upgrades and existing service relationships. This increased demand and resulting administrative challenges required us to take a closer look at whether the current rules and procedures are cost-effective and efficient and adequately protect the Universal Service Fund against waste, fraud, and abuse. Accordingly, in this Report and Order, after reviewing the record,

<sup>1</sup> Press Release, Census Bureau, New Census Data Show Differences in Rural and Urban Populations (Dec. 8, 2016), <https://www.census.gov/newsroom/press-releases/2016/cb16-210.html>.

<sup>2</sup> According to a recent Pew Research survey, “[R]ural Americans are more likely than people in urban and suburban areas to say access to good doctors and hospitals is a major problem in their community” and on average have longer travel times to the nearest hospital. Onyi Lam et al., *How far Americans Live from the Closest Hospital Differs by Community Type*, Pew Research Center (Dec. 12, 2018), <https://www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/>.

we adopt a number of the proposals made in the *2017 Promoting Telehealth Notice and Order*<sup>3</sup> to reform the RHC Program rules to promote transparency and predictability, and further the efficient allocation of limited RHC Program resources.

## II. BACKGROUND

4. The Commission's RHC Program consists of two component programs: (1) the Telecommunications (Telecom) Program; and (2) the Healthcare Connect Fund Program. Established in 1997, the Telecom Program subsidizes the difference between urban and rural rates for telecommunications services.<sup>4</sup> Eligible rural health care providers can obtain rates on telecommunications services for their rural health care facilities that are reasonably comparable to rates charged for similar services in corresponding urban areas.<sup>5</sup> The Telecom Program rules have not undergone any significant changes since their creation more than two decades ago. The Healthcare Connect Fund Program, created in 2012, was intended to promote the use of broadband services and facilitate the formation of health care provider consortia<sup>6</sup> by providing a flat 65% discount on an array of advanced telecommunications and information services.<sup>7</sup> These services include Internet access, dark fiber, business data, traditional Digital Subscriber Line, and private carriage services.<sup>8</sup>

5. As millions in rural America face ever fewer options for affordable, quality medical treatment at the local level,<sup>9</sup> telehealth services supported through the RHC Program help to bridge this gap and are making a difference.<sup>10</sup> According to the American Hospital Association, 65% of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and

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<sup>3</sup> See *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631 (2017) (*2017 Promoting Telehealth Notice and Order*); *Wireline Competition Bureau Seeks Additional Comment on Determining Urban and Rural Rates in the Rural Health Care Program*, WC Docket No. 17-310, Public Notice, 33 FCC Rcd 11707 (WCB 2018) (*2018 Refresh Public Notice*). Appendix C provides a list of abbreviated names of commenters and reply commenters in response to the *2017 Promoting Telehealth Notice and Order* and the *2018 Refresh Public Notice*.

<sup>4</sup> See 47 U.S.C. § 254(h)(1)(A); *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-161, paras. 608-749 (1997) (*Universal Service First Report and Order*).

<sup>5</sup> See 47 U.S.C. § 254(h)(1)(A); *Universal Service First Report and Order*, 12 FCC Rcd at 9093-161, paras. 608-749.

<sup>6</sup> See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, para. 1 (2012) (*Healthcare Connect Fund Order*).

<sup>7</sup> See 47 U.S.C. § 254(h)(2)(A); 47 CFR § 54.633; *Healthcare Connect Fund Order*, 27 FCC Rcd at 16680-81, paras. 1-3.

<sup>8</sup> See 47 CFR § 54.634. The two RHC Programs are focused on improving access to communications services at health care facility sites; however, the Commission has separately initiated a proceeding to evaluate a Connected Care Pilot Program to facilitate the delivery of telehealth services to low-income Americans beyond the premises of the health care facility. See *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Inquiry, 33 FCC Rcd 7825 (2018).

<sup>9</sup> American Hospital Association, *Rural Report, Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care* at 7 (2019), <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

<sup>10</sup> In this Report and Order, we refer to “telehealth” as meaning the “broad range of health care-related applications that depend upon broadband connectivity, including telemedicine; exchange of electronic health records; collection of data through Health Information Exchanges and other entities; exchange of large image files (e.g. X-ray, MRIs, and CAT scans); and the use of real-time and delayed video conferencing for a wide range of telemedicine, consultation, training, and other health care purposes.” See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16680, para. 1 & n.1.

other technology.<sup>11</sup> The University of Virginia Health System, for example, connects 153 sites across Virginia using high definition video-conferencing, store-and-forward technologies, remote patient monitoring, and mobile health tools. This network allows for 60 different clinical subspecialties in rural areas, facilitating more than 65,000 live interactive patient consultations and follow-up visits with high definition video.<sup>12</sup> The Medical University of South Carolina, part of the Palmetto State Providers Network, provides 77 unique telehealth services to more than 200 sites in 27 South Carolina counties and has witnessed a dramatic growth in annual telehealth interactions from 1,078 in 2013 to more than 235,000 in 2017.<sup>13</sup> In Mississippi, the University of Mississippi Medical Center (UMMC) offers telehealth in more than 35 specialties, and tele-emergency care with emergency departments in 17 rural hospitals. The UMMC health system connects more than 200 health care locations across the state, accounting for approximately 500,000 patient visits in 69 of the state's 82 counties.<sup>14</sup> The Oregon Community Health Information Network and California Telehealth Network have collaborated to use RHC Program funding to connect over 800 health care providers over the last seven years.<sup>15</sup> The New England Telehealth Consortium now encompasses 890 sites across six northeastern states enabling the provision of tele-psychiatry to rural patients, and the digital transition to cloud-based applications, including an Electronic Health Records solution.<sup>16</sup> In Skagway, Alaska, with a population of less than one thousand, the Dahl Memorial Clinic uses broadband telehealth services to send x-ray and ultrasound imaging to radiologists over a hundred miles away in Juneau for reading and interpretation.<sup>17</sup> The number of telemedicine visits among rural Medicare beneficiaries has also grown rapidly in recent years, further evidencing the increased availability and adoption of telehealth in rural areas.<sup>18</sup>

6. With the rapid increase in the number and overall amount of RHC Program funding requests, the Commission initiated a proceeding in December 2017 to re-evaluate the rules and procedures to better promote the efficient allocation of limited funds and provide predictability and transparency for the RHC Program.<sup>19</sup> Specifically, the Commission, in addition to proposing adjustments to the RHC Program funding cap, sought comment on whether and how to reform the calculation of urban

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<sup>11</sup> American Hospital Association, Fact Sheet: Telehealth (2018), <https://www.aha.org/system/files/2018-04/fact-sheet-telehealth-2018.pdf>.

<sup>12</sup> *The Universal Service Fund and Rural Broadband Investment: Hearing before the S. Subcomm on Communications, Technology, Innovation and the Internet of the S. Comm on Commerce, Science, and Transportation*, 115th Cong. 189-90 (2017) (statement of Karen S. Rheuban, Director for the Center for Telehealth, University of Virginia).

<sup>13</sup> American Hospital Association, Taking Telehealth to the Next Level Nationally: Telehealth Centers of Excellence at 2 (2018), <https://www.aha.org/system/files/2018-03/telehealth-centers-of-excellence-musc-ummc.pdf>.

<sup>14</sup> *Id.*

<sup>15</sup> OCHIN Comments at 1.

<sup>16</sup> NETC Comments at 1-2.

<sup>17</sup> DMC Comments at 1.

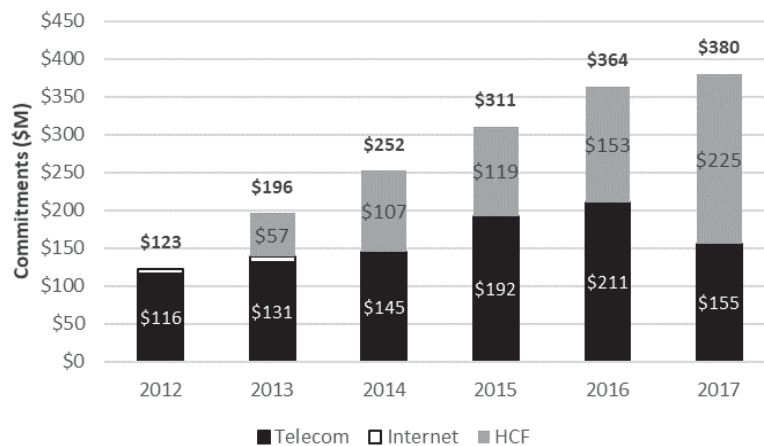
<sup>18</sup> Telemedicine visits among rural Medicare beneficiaries increased from 7,015 in 2004 to 107,955 in 2013. Ateev Mehrotra et al., *Utilization of Telemedicine Among Rural Medicare Beneficiaries* (May 10, 2016), <https://jamanetwork.com/journals/jama/fullarticle/2520619>; see also Centers for Medicare & Medicaid Services, Information on Medicare Telehealth at 2 (2018), <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf> (“In 2016, almost 90,000 Medicare fee-for-service beneficiaries utilized 275,199 telehealth services . . . . The ten states with the highest utilization of telehealth services are Texas, Iowa, California, Missouri, Michigan, Minnesota, Wisconsin, Georgia, Virginia, and Kentucky.”).

<sup>19</sup> See 2017 Promoting Telehealth Notice and Order, 32 FCC Rcd at 10634, para. 4.

and rural rates used to determine the amount of support available to health care providers under the Telecom Program.<sup>20</sup>

7. In June 2018, following two years in which RHC Program demand exceeded the \$400 million cap, the Commission adopted an order increasing the cap to \$571 million for funding year 2017 with adjustments for inflation each subsequent funding year.<sup>21</sup> Even with an adjusted cap of \$581 million for funding year 2018, gross RHC Program demand again exceeded the cap, requiring the Commission to take action to avoid the need to prorate support for applicants.<sup>22</sup> The following charts illustrate the steady rise in RHC Program funding commitments for funding years 2012-2017 and a comparison of the gross amounts requested for funding years 2017 and 2018 by program and applicant type.

**Fig. 1: Original Commitment Amounts (\$) by Funding Year and Program<sup>23</sup>**

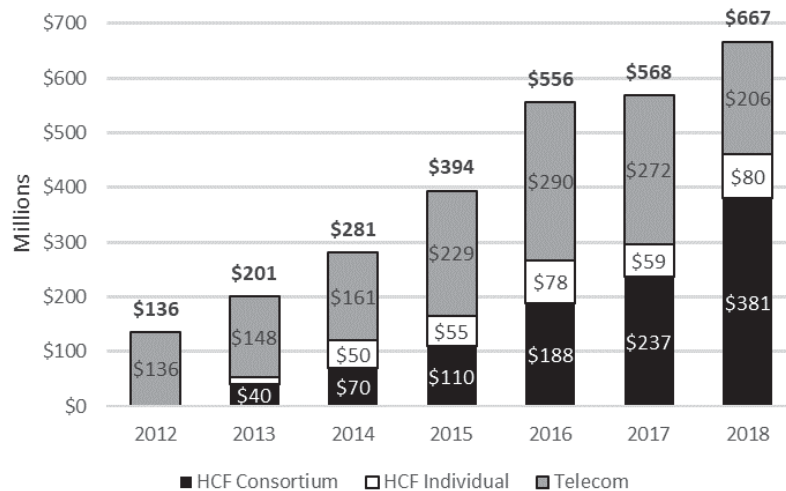


<sup>20</sup> *Id.*

<sup>21</sup> See *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 33 FCC Rcd 6574, 6578, para. 9 (2018) (*2018 Report and Order*).

<sup>22</sup> See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, FCC 19-45, 2019 WL 2205954 (May 20, 2019) (*2019 Order*) (suspending multi-year funding commitments for funding year 2018). The RHC Program funding cap for funding year 2019 is approximately \$594 million. As of the third quarter of 2019, the Administrator projects that approximately \$83 million in unused funds will be available for use in future funding years beginning in funding year 2019. See *WCB Announces E-Rate and RHC Programs' Inflation-Based Caps for Funding Year 2019*, CC Docket No. 02-6, WC Docket No. 02-60, Public Notice, 34 FCC Rcd 1138 (WCB 2019); *WCB Announces the Availability of Unused Funds to Increase Rural Health Care Program Funding for Funding Year 2019*, WC Docket No. 02-60, Public Notice, DA 19-540, 2019 WL 2461902 (WCB June 10, 2019).

<sup>23</sup> Figure 1 is based on data reported to, and maintained by, the Administrator. See Letter from Mark Sweeney, Vice President Rural Health Care Division and Shared Services, Universal Service Administrative Company, to Ryan Palmer, Chief, Telecommunications Access Policy Division, Wireline Competition Bureau, and Elizabeth Drogula, Deputy Chief, Telecommunications Access Policy Division, Wireline Competition Bureau, WC Docket No. 17-310, at Appx. A, p. 1 (July 9, 2019) (*USAC Data Submission*). The original commitment amount is the amount of support originally committed pursuant to the applicant's funding request and does not reflect subsequent commitment adjustments due to modification requests, recovery actions, or the expiration of service delivery deadlines, where applicable. These amounts do not reflect expenses associated with administering the RHC Program.

**Fig. 2: Gross Demand by Program and Funding Year<sup>24</sup>**

8. With the RHC Program cap now adjusted pursuant to the *2018 Report and Order*, we turn our focus now to the reform efforts contemplated in the *2017 Promoting Telehealth Notice and Order*.

### III. DISCUSSION

#### A. Improving Transparency, Predictability, and Efficiency for the Telecom Program

9. The Telecom Program is rooted in section 254(h)(1)(A) of the Communications Act, as amended by the Telecommunications Act of 1996 (the Act).<sup>25</sup> This statutory provision allows eligible health care providers to obtain telecommunications services in rural areas at rates comparable to the rates charged to customers in urban areas for similar services in a state. Section 254(h)(1)(A) is intended “to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide . . . medical services to all parts of the Nation.”<sup>26</sup> The statute

<sup>24</sup> Figure 2 is based on data reported to, and maintained by, the Administrator. See *USAC Data Submission* at Appx. A, p. 1; Letter from Mark Sweeney, Vice President Rural Health Care Division and Shared Services, Universal Service Administrative Company, to Ryan Palmer, Chief, Telecommunications Access Policy Division, Wireline Competition Bureau, and Elizabeth Drogula, Deputy Chief, Telecommunications Access Policy Division, Wireline Competition Bureau, WC Docket. No. 17-310, at Appx. A, p. 1 (July 31, 2019) (*USAC Second Data Submission*). Gross demand is the original amount an applicant requests with their FCC Forms 462 or 466. If the application is approved, the amount committed may be higher or lower than the gross demand requested. “HCF Consortium” refers to requests submitted by a consortium on behalf a member, and “HCF Individual” refers to requests filed by an individual health care provider.

<sup>25</sup> Section 254(h)(1)(A) provides: “A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State. A telecommunications carrier providing service under this paragraph shall be entitled to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service.” 47 U.S.C. § 254(h)(1)(A).

<sup>26</sup> H.R. Rep. No. 104-458, at 132 (1996) (Conf. Rep.) (Joint Explanatory Statement).



also limits the types of health care providers that can receive the services supported by the RHC Program. Health care providers eligible for discounts include: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; and (8) consortia consisting of eligible health care providers.<sup>27</sup>

10. Over the years, commitments for Telecom Program funding consistently increased until funding year 2017, when demand declined slightly and commitments fell to \$155 million, or less than half of the overall RHC Program demand for the first time.<sup>28</sup> Telecom Program demand data shows a significant distribution of program support across the lower 48 states of the nation and Alaska.<sup>29</sup> The proportion of original commitments allocated to Alaska has increased significantly over time with more than half of the total number of original commitments for the Telecom Program being issued for Alaska since funding year 2014 and in subsequent funding years.<sup>30</sup> The Telecom Program provides eligible health care providers with a discount on telecommunications services so they can purchase services at rates reasonably comparable to the rates paid for similar services in urban areas as directed by the statute. The amount of the discount is the difference between the urban and rural rate calculated under the Commission's rules.<sup>31</sup> The current system requires health care providers to identify the urban and rural rates for an eligible service and submit that information to the Universal Service Administrative Company (the Administrator) in their funding applications.<sup>32</sup> To do this, health care providers often (and in some cases, must) rely on information obtained from carriers. Ultimately, the urban rate identified by the health care provider is what the health care provider pays for the service. Accordingly, the health care provider has an incentive to identify the lowest urban rate possible for the requested service in the state to minimize its out-of-pocket expense. The Telecom Program compensates carriers for the difference between the rural rate and corresponding urban rate for the service as identified under our rules. The carrier, therefore, also has an incentive to identify the highest rural rate it can justify to maximize the support received.<sup>33</sup>

11. Under existing Telecom Program rules, the process of determining the urban and rural rates is cumbersome, and the current system lacks transparency. Health care providers individually

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<sup>27</sup> 47 U.S.C. § 254(h)(7); 47 CFR § 54.600(a).

<sup>28</sup> See *supra* Fig. 1.

<sup>29</sup> See USAC, RHC Program Fund Distribution (FY2017), FY2017 Original Commitment Data, <https://www.usac.org/rhc/tools/funding-commitments/overview.aspx> (last visited July 9, 2019) (*USAC May 31, 2019 Commitment Data Spreadsheet*).

<sup>30</sup> See *USAC May 31, 2019 Commitment Data Spreadsheet*. Initial estimates from the Administrator indicate that gross Telecom Program demand for funding year 2019 is approximately \$257 million, and that approximately \$205 million of those dollars (i.e., 80%) have been requested by health care providers in Alaska. See *USAC Data Submission* at Appx. A, p. 2. For funding year 2018, gross demand for Alaska was about \$137.5 million, i.e., 67% of the total Telecom Program gross demand. *Id.* In comparison, little funding is sought by, and committed to, health care providers in Alaska under the Healthcare Connect Fund Program. See *USAC May 31, 2019 Commitment Data Spreadsheet*.

<sup>31</sup> See 47 CFR §§ 54.605, 54.607.

<sup>32</sup> This information is reported by the health care provider on the FCC Form 466. FCC Form 466 Instructions, Rural Health Care Universal Service Mechanism, OMB 3060-0804 (July 2014) (FCC Form 466 Instructions).

<sup>33</sup> For example, in practice, the service provider offers service to a rural health care provider at a price that effectively becomes the basis for a rural rate. The rural health care provider then reports this rural rate in its request for support but will likely need the service provider's assistance to obtain the necessary documentation to support the rural rate reported. See Part III.A.4 (discussing current approved methodologies for determining a rural rate).

determine, according to our rules, the rates used to set the program discount.<sup>34</sup> Health care providers are further required to submit documentation substantiating their requested urban and rural rates to the Administrator with their funding applications;<sup>35</sup> however, the information submitted by a health care provider in support of a particular funding request is not publicly available for review by other service or health care providers looking to compare and scrutinize the rates. Consequently, the Administrator must either accept the rate information submitted by the health care provider or conduct a burdensome investigation of the submitted rates.<sup>36</sup> Conducting such investigations on a case-by-case basis for thousands of Telecom Program funding requests filed each year is a laborious, time-intensive task in a program where the speed of funding decisions may determine vital outcomes. Not conducting investigations, on the other hand, may favor those more willing to manipulate our current approach, and thus reduces funding otherwise available to other health care providers and thwarts the purpose of the RHC Program to support the delivery of critical health care services to rural America.

12. Placing responsibility for determining urban and rural rates in the hands of health care and service providers also leads to potentially arbitrary and substantial inconsistencies in rates for similar services, depending on the service and health care provider involved. For example, the rural rates identified for a 10 Mbps Ethernet service for two different health care provider sites in the same county could differ significantly depending on how the determinations were performed. In a situation where the carrier did not previously serve the subject area, the rural rate for its service is calculated by “averaging tariffed and other publicly available rates charged by other service providers for same or similar services.”<sup>37</sup> Two different health care providers could thus have different rural rates for a 10 Mbps Ethernet service line in the same county unless the same pool of similar services were identified or the different pools which they identified had the same average, neither of which is likely. For example, in funding year 2017, in Tulare County, California, “rural rates” in the towns of Earlimart and Woodlake for 10 Mbps Ethernet service ranged from \$420 a month to \$4,308 a month.<sup>38</sup>

13. In short, the current system of Telecom Program rate determinations results in wasteful spending, fraud, and abuse as reflected in recent enforcement actions;<sup>39</sup> is not serving the statute as intended; and is causing a significant drain on the limited resources of the Telecom Program. We thus take the following steps to reform the Telecom Program: (1) clarify the scope of similar services for rate

<sup>34</sup> See FCC Form 466 Instructions.

<sup>35</sup> See 47 CFR § 54.609(a)(2); *WCB Provides Guidance Regarding the Commission’s Rules for Determining Rural Rates in the Rural Health Care Telecommunications Program*, WC Docket No. 02-60, Public Notice, 34 FCC Rcd 533 (WCB 2019) (*February 2019 Public Notice*); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 30 FCC Rcd 230 (WCB 2015) (*FCC Form 466 Documentation Order*) (requiring health care providers to submit documentation supporting the requested urban and rural rates).

<sup>36</sup> For instance, where a rural rate is based on tariffs and other available rate data, a health care provider may submit supporting tariffs, rate cards, and other available information to substantiate the rate. The Administrator has no way of knowing whether other rate information exists that may lower the rural rate, however, without conducting its own review of the rate information available in the health care provider’s rural area.

<sup>37</sup> *February 2019 Public Notice*, 34 FCC Rcd at 534-35.

<sup>38</sup> See USAC, *Rural Health Care Commitments and Disbursements (FCC Form 462/466/466A)*, <https://opendata.usac.org/Rural-Health-Care/Rural-Health-Care-Commitments-and-Disbursements-FC/2kme-evqq> (last visited July 5, 2019) (*RHC Program Open Data Platform*).

<sup>39</sup> See, e.g., *DataConnex, LLC*, Notice of Apparent Liability for Forfeiture and Order, 33 FCC Rcd 1575 (2018) (*DataConnex NAL*) (proposing an approximately \$19 million forfeiture for alleged violations of the Commission’s rules, including the use of documents containing forged, false, misleading, and unsubstantiated information, including material misrepresentations, to increase its receipt of payments from the Telecom Program); *Network Services Solutions, LLC, Scott Madison*, Amendment to Notice of Apparent Liability for Forfeiture and Order, 32 FCC Rcd 5169 (2017) (proposing an approximately \$22 million forfeiture for alleged violations including preparing and transmitting apparently forged and false urban rate documents).



determination; (2) define the geographic contours of urban and comparable rural areas for rate determination; (3) reassign to the Administrator the task of determining urban and rural rates for similar services from health care and service providers; (4) reform the determination of rates based on the median of all available rates for functionally similar services; (5) direct the Administrator to create a publicly available database for the posting of urban and rural rates; (6) eliminate the limitation on support for satellite services; and (7) eliminate distance-based support.<sup>40</sup>

### 1. Defining Similar Services for Determining Rates

14. The amount of the discount health care providers receive in the Telecom Program is the difference between the urban rate, which must be “reasonably comparable to the rates charged for *similar services* in urban areas in that State,” and the rural rate—i.e., “the rates for *similar services* provided to other customers in comparable rural areas.”<sup>41</sup> As the Commission recognized, the currently outdated speed tiers “ha[ve] led to significant variability in how the ‘similar services’ analysis is conducted and is a potential source of waste.”<sup>42</sup> Thus, we now place the burden of identifying “similar services” for rate determination on the Administrator. This approach will reduce health care provider burdens and will also preclude manipulation of urban and rural rates through *ad hoc* assessments of service similarity by service and health care providers. It will also promote a more equitable distribution of program funding by ensuring that funding requests for Telecom Program support are consistently evaluated and based on the same parameters.

15. As proposed, we retain the existing requirement that the similarity of services be determined from the perspective of the end user, rather than technical similarity of the services,<sup>43</sup> and direct the Administrator to evaluate whether services are similar based on that.<sup>44</sup> For purposes of determining functional similarity, the Administrator will consider other services with advertised speeds 30% above or below the speed of the requested service. For example, for a health care provider requesting a 50 Mbps service, the Administrator would examine rates for services with an advertised speed 30% above or below 50 Mbps, or between 35 Mbps and 65 Mbps, to determine the urban and rural rates for that service.<sup>45</sup>

16. The current designated speed tiers, in effect since 2003,<sup>46</sup> which are fixed and do not include speeds above 50 Mbps, have failed to keep pace with the rising demand for faster connectivity.<sup>47</sup>

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<sup>40</sup> We acknowledge that in some circumstances the Administrator has approved urban and rural rates for evergreen contracts entered before the adoption of this Report and Order. See ACS July 19, 2019 *Ex Parte* Letter at 7. To avoid confusion, health care and service providers may continue to rely on the previously approved urban and rural rates in their FCC Form 466 filings for the initial term of such evergreen contracts and for the term of any voluntary options to extend that are executed by the date that this Report and Order is adopted. This includes cost-based rural rates for interstate services that have been approved by the Commission. Health care and service providers may not rely on the previously approved urban and rural rates for any unexecuted options to extend an evergreen contract beyond the effective date of the rules for determining urban and rural rates adopted by this Report and Order.

<sup>41</sup> See 47 U.S.C. § 254(h)(1)(A) (emphasis added).

<sup>42</sup> 2017 *Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10655, paras. 73-74 (“For example, due to the highest tier grouping all bandwidths of 50 Mbps or higher, in determining the applicable discount rate for a 60 Mbps service under the safe-harbor, the average rural rate could be set based on rates for two services at 200 Mbps and three services at 500 Mbps, all of which are priced significantly higher than the undiscounted price for the 60 Mbps service.”).

<sup>43</sup> *Id.* at 10655, para. 75. See also *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 18 FCC Rcd 24546, 24563, para. 33 (2003) (2003 *RHC Internet Access Order*).

<sup>44</sup> See 2003 *RHC Internet Access Order*, 18 FCC Rcd at 24563, para. 33.

<sup>45</sup> 2017 *Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10655-56, para. 76.

<sup>46</sup> See 2003 *RHC Internet Access Order*, 18 FCC Rcd at 24564, para. 34. The Commission also established voluntary “safe harbor” categories of functionally equivalent advertised speeds that health care providers and service  
(continued....)

Some commenters supported simply updating the existing tiers, but we find using a range more appropriate.<sup>48</sup> A range based on the requested service speed eliminates the need to continually update the speed tiers to reflect advances in technology. Moreover, we anticipate a 30% range will provide a sufficiently large range of functionally similar services to enable reasonable rate comparisons.<sup>49</sup> While the universe of functional equivalents may be larger in limited cases, depending on the telecommunications service, we find a 30% range strikes the appropriate balance to furthering specific, predictable, and sufficient mechanisms to preserve and advance universal service while ensuring rural health care providers obtain telecommunications services at reasonable comparable rates for similar services.<sup>50</sup>

17. We also agree with commenters that factors other than bandwidth are relevant to whether a service is functionally similar.<sup>51</sup> Rural health care providers may have mission critical needs requiring highly secure and reliable telecommunications services for which a dedicated service offering is necessary. In these instances, a best-efforts service may not be functionally similar.<sup>52</sup> In future funding years, we expect health care providers to indicate whether they require a dedicated service or other service level guarantees when they seek bids for eligible services. By doing so, the question of whether dedicated and best-efforts services are similar from the perspective of the end user will be in the hands of the end user (i.e., the health care provider requesting the service). If a health care provider does not indicate a need for dedicated services, or is otherwise silent on the subject in its competitive bidding documentation, then the Administrator may reasonably conclude that best-efforts services are sufficient from the perspective of the health care provider. Where a health care provider specifies that it requires a dedicated service or other service level guarantees, we instruct the Administrator to take that into account

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providers could use to compare services: (1) low - 144-256 Kbps; (2) medium - 257-768 Kbps; (3) high - 769-1400 Kbps (1.4 Mbps); (4) T-1 - 1.41-8 Mbps; and (5) T-3 - 8.1-50 Mbps). *Id.*

<sup>47</sup> See, e.g., Letter from Karen Brinkmann, Counsel for ACS, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 17-310, Attach. at 3-6 (filed May 20, 2019).

<sup>48</sup> See ACS Comments at 32-34; NCTA Comments at 3-4; TeleQuality Comments at 3.

<sup>49</sup> GCI states the use of a 30% range could result in the identification of similar services at dissimilar rates—but this confuses the purpose of the similar services inquiry, which is to identify services that are functionally similar to the end user and not to identify services that are similarly priced. GCI July 23, 2019 *Ex Parte* Letter at 3. GCI and USTelecom both assert that the Administrator should account for discounts included in rates for high volume, long term contracts when determining the rural rates for services. See GCI Second July 25, 2019 *Ex Parte* Letter at 10; USTelecom July 25, 2019 *Ex Parte* Letter at 2. The statute provides that telecommunications carriers, upon receiving a bona fide request, will provide telecommunications services to eligible rural health care providers at “rates that are reasonably comparable to rates charged for similar services in urban areas . . .” 47 U.S.C. § 254(h)(1)(A) (emphasis added). This language limits our discretion to remove these discounts included in charged rates. *Id.* We note, however, that using the median instead of a mean to determine rates will mitigate any potential impact term or volume discounts may have on the rate calculation. In addition, carriers may seek a waiver of the rural rate determination if they confront unique circumstances unanticipated by this rule change. The petition for waiver criteria are set forth in Part III.A.4.b.

<sup>50</sup> Only NCTA discussed an appropriate bandwidth speed percentage range for evaluating similar services, suggesting a smaller range of 10-15% for functionally similar best-efforts services. NCTA Comments at 3-4. We propose to separately take into account service reliability as a factor for evaluation as discussed herein and therefore decline to have a separate, narrower range just for best-efforts services as compared to other types of service offerings, which would unnecessarily add another layer of complexity.

<sup>51</sup> See ACS Comments at 32-34; ADS Comments at 3; NCTA Comments at 3-4.

<sup>52</sup> This is not intended to mean that all health care provider needs are mission critical and require dedicated services. Health care providers may indeed have non-mission critical needs where reliability is not as important and a best-efforts service will suffice.

when identifying functionally similar services for rate comparisons.<sup>53</sup> For the same reasons, we also retain the Commission’s earlier conclusion that the Administrator should consider whether the requested service is symmetrical or asymmetrical when assessing functional similarity of services for rate comparisons. Depending on the health care provider’s identified needs, asymmetrical services would not be functionally similar to the requested service because they would not fulfill those needs. We direct the Wireline Competition Bureau and the Administrator to work on any appropriate revisions to the competitive bidding forms that will enable health care providers to provide the necessary information.

18. Additionally, we direct the Administrator not to limit the functionally similar inquiry to solely telecommunications services.<sup>54</sup> The Telecom Program is statutorily limited to supporting telecommunications services but determining similarity of services is a technology-agnostic inquiry as to whether there are functionally equivalent substitutes from the end user’s viewpoint. The end-user experience is not dictated by regulatory classification. Therefore, we do not agree with USTelecom that it is “inappropriate” to determine median rates for telecommunications services using non-telecommunications service rates and instruct the Administrator to expand the inquiry beyond telecommunications to other services, including functionally equivalent private carriage and information services.<sup>55</sup>

19. Expanding the inquiry not only more closely aligns with the functionally similar standard but also with the statutory language directing us to ensure access to telecommunications services by health care providers at rates “reasonably comparable” to those charged for “similar services in urban areas.”<sup>56</sup> For example, we anticipate the inclusion of less expensive, information services that are nonetheless functional substitutes will result in lower urban rates than if only similar telecommunications services are considered. Accordingly, health care providers will likely pay less for telecommunications services supported by the Universal Service Fund, reflecting the availability of lower priced alternatives in urban areas. This result should place health care providers on a more equal footing with their urban counterparts, as intended by the statute, than if non-telecommunications services were excluded from the similar services inquiry.

20. And as with urban rates, expanding the similar services inquiry could also serve to lower rural rates by increasing the pool of services to include similar information services when determining the rural rate.<sup>57</sup> A lower rural rate determination, in turn, decreases the support ceiling and thus could further

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<sup>53</sup> To implement this instruction, the Administrator may need to determine and publish two types of rates in its urban and rural rate database—one applicable to funding requests for which bids were only sought for dedicated services and one applicable to funding requests for which responsive bids were not so limited.

<sup>54</sup> In the *2003 RHC Internet Access Order*, the Commission stated, “[e]ligible health care providers must purchase telecommunications services and compare their service to a functionally equivalent *telecommunications service* in order to receive this discount.” See *2003 RHC Internet Access Order*, 18 FCC Rcd at 24564, para. 33 (emphasis added).

<sup>55</sup> See USTelecom July 25, 2019 *Ex Parte* Letter at 2-3. In the *2017 Promoting Telehealth Notice and Order*, the Commission specifically sought comment on whether it should revise its statutory interpretation of similar services for purposes of the Telecom Program, which invariably includes the scope of services for consideration. *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10655-56, paras. 73-78. Accordingly, we also disagree with USTelecom that the Commission lacks notice as required by the Administrative Procedure Act to expand the similar services inquiry to include non-telecommunications services. See USTelecom July 25, 2019 *Ex Parte* Letter at 2-3; see also GCI July 29, 2019 *Ex Parte* Reply Letter at 4 & n.23.

<sup>56</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>57</sup> See *Business Data Services in an Internet Protocol Environment*, WC Docket No. 16-143, Report and Order, 32 FCC Rcd 3459, 3461, para. 3 (*2017 BDS Report and Order*) (“These rapidly increasing bandwidth demands will place an ever-increasing demand for services such as Ethernet, especially over fiber, which can scale bandwidth to meet these requirements more effectively than can the old legacy services.”).

reduce demand on the Universal Service Fund.<sup>58</sup> An expanded inquiry will also alleviate administrative burdens by eliminating the need for the Administrator to identify the regulatory classification of commercially available services when determining urban and rural rates. Lastly, expanding the similar services inquiry to include other services will further serve the Commission's overall directive to act in a competitively neutral manner.<sup>59</sup>

## 2. Defining Geographic Contours for Determining Rates

21. Section 254(h)(1)(A) of the Act requires carriers to provide rural health care providers, upon receiving a bona fide request, with telecommunications services at rates reasonably comparable to those charged in urban areas of the state.<sup>60</sup> The provisioning carrier is then entitled to receive support in the amount of the difference between the urban rate charged and the "rates for similar services provided to other customers in comparable rural areas in the state."<sup>61</sup> To determine the urban rate, we will use "urbanized areas" as designated by the Census Bureau based on the most recent decennial Census to define the geographic contours of urban areas in a state.<sup>62</sup> We conclude that urbanized areas are appropriate because they include urban cores with at least 50,000 people "along with adjacent territory containing non-residential urban land uses as well as territory with low population density included to link outlying densely settled territory with the densely settled core."<sup>63</sup> For determining rural rates we establish three tiers of rurality to determine the comparable rural areas in a state or territory.<sup>64</sup>

<sup>58</sup> However, with the corresponding lowering of urban rates, the effect on support demand could in instances be net neutral.

<sup>59</sup> See, e.g., 47 U.S.C. § 254(h)(2) ("The Commission shall establish competitively neutral rules."). The expanded scope means the Administrator could consider satellite services when determining whether a service is a similar service provided the speed and service level commitments are comparable. This is consistent with comments urging the Commission to include the rates of satellite services when considering functionally similar services. See ACS Comments at 45; USTelecom Comments at 17. GCI contends that directing the Administrator to use non-telecommunications services when making a functionally similar services inquiry violates non-delegation principles. See GCI Second July 25, 2019 *Ex Parte* Letter at 8. For the reasons explained below, we reject GCI's position. See *infra* para. 87.

<sup>60</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>61</sup> *Id.*

<sup>62</sup> See Census Bureau, *List of Urbanized Areas and Urban Clusters 2010*, [https://www2.census.gov/geo/pdfs/maps-data/maps/reference/2010UAUC\\_List.pdf](https://www2.census.gov/geo/pdfs/maps-data/maps/reference/2010UAUC_List.pdf) (last visited June 4, 2019). As a result of the 2010 Census, there are 486 urbanized areas in the United States, 11 urbanized areas in Puerto Rico, and no urbanized areas in the island areas of Guam, American Samoa, Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands, for a total of 497 urbanized areas. For the island areas lacking a designated urbanized area, we will instead use the following urban clusters designated for these areas by the Census Bureau as they are the largest urban designations based on the most recent decennial census population: Dededo-Machanao-Apotgan, Guam – pop. 139,825 (UC 22811); Charlotte Amalie-Tutu, U.S. Virgin Islands – pop. 50,916 (UC 15697); Tafuna, American Samoa – pop. 43,450 (UC 86369); and Garapan-Dandan, Commonwealth of the Northern Mariana Islands – pop. 46,203 (UC 32506). See Department of Commerce, Bureau of the Census, *Qualifying Urban Areas for the 2010 Census*, 17 Fed. Reg. 18652 (Mar. 27, 2012). The Commission previously designated as urban the following areas, which are either encompassed or largely encompassed in the urban cluster designations we adopt today: "American Samoa, the island of Tutuila; for CNMI, the island of Saipan; for Guam, the town of Agana; and for the U.S. Virgin Islands, the town of Charlotte Amalie." *Universal Service First Report and Order*, 12 FCC Rcd at 9137-38, para. 697.

<sup>63</sup> See Office of Mgmt. & Budget, Exec. Office of the President, OMB Bull. No. 13-01, *Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas*, at App. 2 (2013); Census Bureau, *2010 Census Urban Areas FAQs*, [https://www2.census.gov/geo/pdfs/reference/ua/2010ua\\_faqs.pdf](https://www2.census.gov/geo/pdfs/reference/ua/2010ua_faqs.pdf) (last visited May 28, 2019).

<sup>64</sup> We do not adopt any substantive change to the "rural area" definition for the purposes for determining eligibility. We continue to believe that a definition based on the Census Bureau's Core Based Statistical Areas is the most reliable measure of rural areas for that purpose, and one that specifically avoids the over-inclusiveness and under-  
(continued....)

Specifically, the rural rate will be determined using the following tiers in which a health care provider is located: (1) *Extremely Rural*, areas entirely outside of a Core Based Statistical Area; (2) *Rural*, areas within a Core Based Statistical Area that does not have an Urban Area with a population of 25,000 or greater; and (3) *Less Rural*, areas in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but are within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000.<sup>65</sup> In Alaska, however, given the vast number of communities without access to roads and the unique cost considerations they may face for obtaining service, we further bifurcate the Extremely Rural tier into two sub-tiers. That is, areas in Alaska entirely outside of a Core Based Statistical Area that are inaccessible by road will be treated as Frontier areas for purposes of determining comparable rural rates. Communities outside of a Core Based Statistical Area and accessible by road will be in the Extremely Rural tier.

22. *Geographic Contours for Urban Areas.* The Commission's rules do not explicitly define "urban area" with respect to determining the urban rate. Instead, the rules require the applicant to base the urban rate on rates for similar services charged to a commercial customer in "any city with a population of 50,000 or more" in the state.<sup>66</sup> The contours of the city are the jurisdictional boundaries of the city according to Commission's statements in the *Universal Service First Report and Order*.<sup>67</sup> The Commission chose cities of at least 50,000 people after concluding such cities "are large enough that telecommunications rates based on costs would likely reflect the economies of scale and scope that can reduce such rates in densely populated urban areas."<sup>68</sup> In supporting this decision, the Commission noted that the Metropolitan Statistical Areas designated by the Office of Management and Budget are based on the inclusion of at least one population center with at least 50,000 people.<sup>69</sup>

23. In the *2017 Promoting Telehealth Notice and Order*, the Commission sought comment on how to define the geographic contours of urban areas for purposes of determining the urban rate, specifically asking whether we should modify the city population size of 50,000 or more.<sup>70</sup> Commenters supported retaining the current urban area designation, and no comments were received advocating for a lower city population threshold.<sup>71</sup> Based on this record, we retain the current population threshold of 50,000 in defining the geographic contours of urban areas for purposes of the determining the urban rate.<sup>72</sup>

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inclusiveness of other methodologies. See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613, 24619, para. 11 (2004) (*Rural Health Care Second Report and Order*) (adopting the Core Based Statistical Area-based definition of "rural area"). Given our continued confidence in relying on Core Based Statistical Areas, we are not persuaded by commenters advocating alternative means of defining "rural area" that are more inclusive.

<sup>65</sup> See 47 CFR § 54.605(a), as adopted herein; Appx. A, Final Rules. The terms "Core Based Statistical Area," "Urban Area," and "Place" will be as identified by the Census Bureau.

<sup>66</sup> See 47 CFR § 54.605(a).

<sup>67</sup> See *Universal Service First Report and Order*, 12 FCC Rcd at 9125, para. 669.

<sup>68</sup> *Id.* at 9125, para. 670.

<sup>69</sup> *Id.*

<sup>70</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10654, paras. 70-71.

<sup>71</sup> See, e.g., ACS Comments at 28 (supporting the 50,000 population figure because "competition is almost universally most intense in metropolitan areas"); SpaceX Comments at 4 ("[L]imiting the urban rate to an average rate for a functionally similar service offered in a city of 50,000 or more in the state would . . . provide an objective and independently verifiable standard.").

<sup>72</sup> 47 CFR § 54.600(g), as adopted herein; Appx. A, Final Rules.



24. Consistent with the Commission's conclusion in 1997, we continue to believe that cities with populations of 50,000 or more are large enough so the rates for telecommunications services in these areas reflect cost reductions associated with high-volume, high-density factors.<sup>73</sup> Two comments were received on this issue encouraging retention of the current standard. SpaceX noted that limiting a calculated rate to functionally similar services offered in a city of 50,000 or more would provide an objective and independently verifiable standard.<sup>74</sup> ACS supported retaining the population threshold of 50,000, arguing that "because competition is almost universally most intense in metropolitan areas," the publicly available rate information from the service provider would be reliable.<sup>75</sup>

25. We conclude, however, that defining urban areas by the jurisdictional boundaries of cities is unrealistic and unnecessarily restrictive because it fails to account for adjacent areas that are socioeconomically tied to the urban core. As an example of why this distinction is important, the surrounding areas of Memphis, Tennessee, that lie in neighboring Arkansas and Mississippi, like Horn Lake, Mississippi (population of about 27,000) is part of the Memphis, TN-MS-AR urbanized area, even though they are not within the jurisdictional city boundary of Memphis.<sup>76</sup> Under the Commission's prior formulation, rates available in the Memphis metro area, which includes Horn Lake, would not be considered in determining the urban rate in Mississippi.

26. Failing to include a city's suburban areas runs counter to the goal of using urban rates that reflect the cost reductions associated with higher population density present in urban areas. Omitting such areas is also contrary to how urban areas are designated by the nation's top two Federal agencies on the subject, the Census Bureau and the Office of Management and Budget, both of which evaluate surrounding areas when considering urban designations regardless of a city's jurisdictional boundary.<sup>77</sup> Accordingly, we now update the contours of urban areas for determining urban rates to: (1) more accurately reflect the socioeconomic realities of metropolitan cities and (2) ensure rates relevant to the urban rate determination are not unnecessarily excluded.

27. We note that urbanized areas are used by the Office of Management and Budget to designate Metropolitan Statistical Areas which the Commission originally referenced when establishing the 50,000 population threshold.<sup>78</sup> We decide, however, to use urbanized area designations as opposed to the Metropolitan Statistical Areas to minimize the potential for the inadvertent inclusion of pocket rural areas.<sup>79</sup> Because Metropolitan Statistical Areas are based on counties and urbanized areas designations

<sup>73</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 350, para. 670.

<sup>74</sup> SpaceX Comments at 4.

<sup>75</sup> ACS Comments at 28-29.

<sup>76</sup> See Census Bureau, *QuickFacts – Horn Lake, Mississippi*, <https://www.census.gov/quickfacts/fact/table/hornlakecitymississippi/BZA210216> (last visited July 8, 2019); Census Bureau, *Map for Memphis, TN-MS-AR Urbanized Area (UA 56116)* (Mar. 10, 2012), [https://www2.census.gov/geo/maps/dc10map/UAUC\\_RefMap/ua/ua56116\\_memphis\\_tn--ms--ar/DC10UA56116.pdf](https://www2.census.gov/geo/maps/dc10map/UAUC_RefMap/ua/ua56116_memphis_tn--ms--ar/DC10UA56116.pdf).

<sup>77</sup> ACS Comments at 28-29.

<sup>78</sup> See *Universal Service First Report and Order*, 12 FCC Rcd at 9125-26, para. 670. The Office of Management and Budget designates Core Based Statistical Areas, which consist of Metropolitan Statistical Areas and Micropolitan Statistical Areas. A Metropolitan Statistical Area includes one or more urbanized areas, as designated by the Census Bureau, with a population of at least 50,000 people. A Micropolitan Statistical Area contains at least one urban cluster, as designated by the Census Bureau, of at least 10,000 but less than 50,000 population. See Census Bureau, *Metropolitan and Micropolitan* (Oct. 15, 2018), <https://www.census.gov/programs-surveys/metro-micro/about.html>.

<sup>79</sup> We note that ADS supported basing urban rates on averaging the rates in the top 25 Metropolitan Statistical Areas, but this proposal fails to account for the statutory language requiring rate determinations based on urban areas "in the state." See ADS Comments at 3 and ADS Reply Comments at 1 (based on largest 25 Metropolitan areas "in the state.") (continued....)



consisting of census tracts and blocks, there is a greater likelihood of the less granular Metropolitan Statistical Area containing an area that is rural for purposes of reflecting the costs of deploying telecommunications services.<sup>80</sup> Using urbanized areas thus allows for a more granular designation of high population density areas than attainable with the county-based Metropolitan Statistical Areas.

28. We do clarify, however, that consistent with the statute, the Administrator will review public rates in all urbanized areas to the extent those urbanized areas fall within the boundaries of the state where the health care provider is located. For example, in urbanized areas like the Washington, D.C.-Virginia-Maryland urbanized area that cross multiple state boundaries, this means the Administrator could factor in available rates for determining an urban rate for a service delivered to a health care provider in Virginia from that portion of the urbanized area that falls within the Commonwealth of Virginia. For example, a public rate that is available throughout the urbanized area (i.e., the rate is the same irrespective of location within the urbanized area) could be part of the determination along with a local cable company rate that is only available in northern Virginia. The Administrator could not, however, factor in a local cable company rate that is only available in portions of the urbanized area outside of Virginia, like neighboring areas in Maryland and the District of Columbia.

29. *Geographic Contours for Comparable Rural Areas.* Historically, the Commission has defined “comparable rural areas” to mean the immediate rural area in which the health care provider is located.<sup>81</sup> We now conclude, however, that the better, more inclusive interpretation of “comparable rural areas” includes not only rural areas in the health care provider’s own immediate rural location but all similar rural areas, namely all those within the same rural tier in the health care provider’s state. Two rationales support our shift in interpretation. First, the use of the plural “comparable rural areas” in the Act indicates an intent to encompass rates from more than a single area, including, by default, areas where the health care provider is not located. Second, consideration of available rates for services offered across the health care provider’s state provides significantly more service rate data points and thus a more accurate measure of the actual costs of providing services to rural areas.

30. In the *2017 Promoting Telehealth Notice and Order*, the Commission noted that determining rural rates first requires defining the geographic contours of rural areas.<sup>82</sup> The Commission then requested comment on an appropriate way to define rurality in the Rural Health Care context that is simple to understand and apply and on methods (e.g., tiers of rurality) to ensure that rural services are appropriately grouped with services that are similarly rural when calculating the rural rate.<sup>83</sup>

31. Commenters did not specifically address how best to define “rural area” for the purpose of setting rural rates and are split on how to define the term for the purpose of establishing eligibility and

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Service Areas). Moreover, we find for the reasons stated herein, urbanized areas are a better standard for the purpose of determining urban rates than Metropolitan Statistical Areas.

<sup>80</sup> See, e.g., *Rural Health Care Second Report and Order*, 19 FCC Rcd at 24620, para. 14 (providing an example of how a county within a Metropolitan Statistical Area can contain rural areas); see also Census Bureau, *Core-Based Statistical Areas* (Dec. 7, 2016), <https://www.census.gov/topics/housing/housing-patterns/about/core-based-statistical-areas.html> (stating that Metropolitan and Micropolitan Statistical Areas are defined in terms of whole counties or county equivalents); Census Bureau, *2010 Census Urban and Rural Classification and Urban Area Criteria* (Nov. 26, 2018), <https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/2010-urban-rural.html> (noting that urbanized areas and urban clusters consist of “a densely settled core of census tracts and/or census blocks”).

<sup>81</sup> See *Universal Service First Report and Order*, 12 FCC Rcd at 9122, para. 662 (adopting the definition of “comparable rural areas” as the rural area in which the health care provider is located).

<sup>82</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10654, para. 70.

<sup>83</sup> *Id.*

prioritization. Some advocate use of alternative federal definitions<sup>84</sup> or adoption of the definition used in the E-Rate Program.<sup>85</sup> Other commenters are less specific but encourage adoption of a rural rate definition that is consistent, inclusive, or uncomplicated.<sup>86</sup> Commenters recognize that there are degrees of rurality, with ACS, for example, proposing a three-tier system.<sup>87</sup>

32. We note that the existing definition of rural area used for Telecom Program eligibility naturally breaks down into degrees of rurality for the purpose of determining rates in comparable rural areas. Under the existing definition, a rural area is “an area that is entirely outside of a Core Based Statistical Area;<sup>88</sup> is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000.”<sup>89</sup> The following is a map showing the three rural tiers—which we designate Extremely Rural, Rural, and Less Rural, respectively—based on this existing definition.

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<sup>84</sup> See NHeLP Comments at 5 (recommending use of the Census Bureau’s “Urbanized Areas” and “Urban Clusters” definitions); SHLB Reply Comments at 15-16 (recommending use of the Department of Agriculture’s Rural-Urban Commuting Area (RUCA)); SOHCN Reply Comments at 6 (recommending use of Department of Agriculture’s RUCA).

<sup>85</sup> See CPCA Comments at 2.

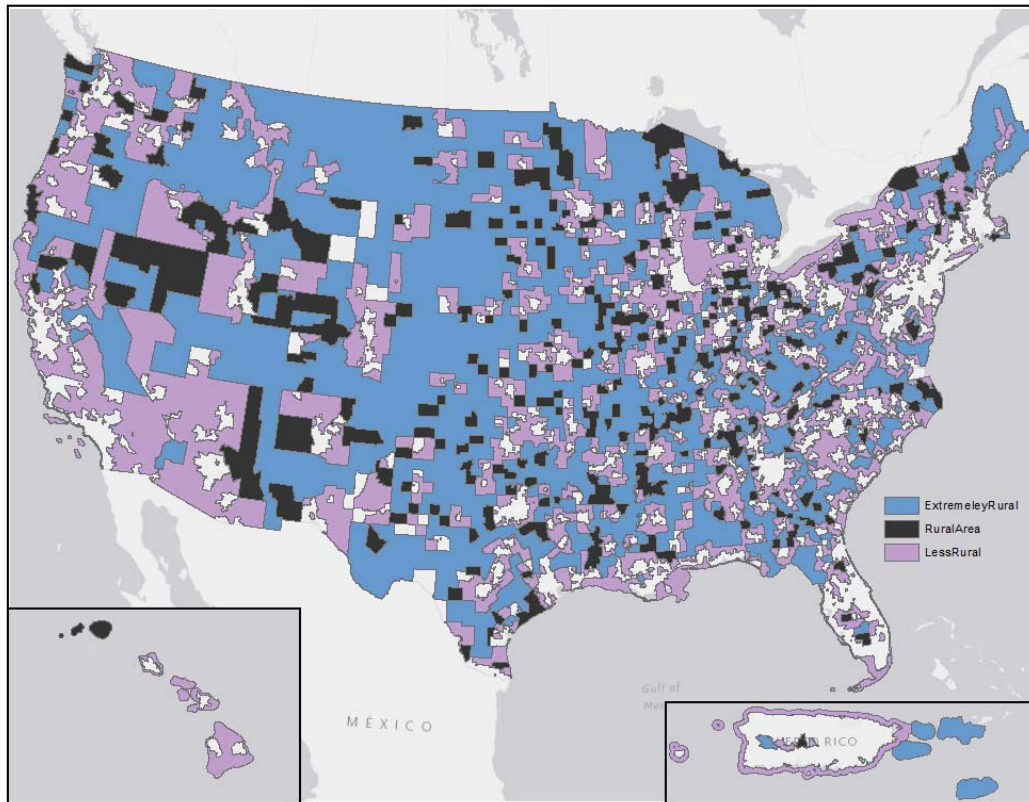
<sup>86</sup> See AAFP Comments at 1 (recommending “consistency in the definition of ‘rural’ in the federal government, unless there is an explicit and demonstrable reason why one use of ‘rural’ would mean something else”); AHA Comments at 17 (recommending an alternative to the current definition that “would be more inclusive, equitable, and consistent with program objectives”); KSLLC Comments at 7 (supporting “a definition of rurality that does not add additional complexity to the program”).

<sup>87</sup> See ACS Public Notice Comments at 9-10 (arguing that when defining “comparable rural areas,” the Commission should rely on characteristics of a geographic area that “are relevant to network economics,” and proposing three location types: on-road, off-road, and satellite); GCI Comments at 43 (proposing “prongs” of rurality to determine priority of payments to healthcare providers); SHLB Comments at 15-17 (recommending that the Commission consider increasing the discount for rural health care providers in the Healthcare Connect Fund Program from the current flat 65% subsidy to an 85% or 95% subsidy based on categories of rurality).

<sup>88</sup> “A Core Based Statistical Area is “a statistical geographic entity consisting of the county or counties associated with at least one core (a densely settled concentration of population, comprising either an urbanized area (of 50,000 or more population) or an urban cluster (of 10,000 to 49,999 population) defined by the Census Bureau) of at least 10,000 people, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties containing the core. Metropolitan and Micropolitan Statistical Areas are the two categories of Core Based Statistical Areas.” *Rural Health Care Second Report and Order*, 19 FCC Rcd at 24618, para. 12 n.44.

<sup>89</sup> 47 CFR § 54.600(b)(1). For purposes of this rule, “Core Based Statistical Area,” “Urban Area,” and “Place” are as identified by the Census Bureau. *Id.*

**Fig. 3: Map Showing the Three Tiers of Comparable Rural Areas in the Contiguous United States, Hawaii, and Puerto Rico<sup>90</sup>**



33. We conclude that using rural area tiers is a more precise means of determining rurality because it prevents rates in the most rural areas from being unfairly reduced by being combined with rates from less rural areas. We base this conclusion on the reasonable assumption that the cost to provide telecommunications services increases as the density of an area decreases, as rates are generally a function of population density. We also find that tying the new rural tiers to the existing three-part definition of “rural area” used for eligibility purposes has the advantage of familiarity, and thus avoids a

<sup>90</sup> This map was created by applying the rurality tier criteria, as provided in the definition of “rural area” in section 54.600(b) of the Commission’s rules against the 2010 Census data and corresponding designations for urban areas and clusters by the Census Bureau and Core Based Statistical Areas by the Office of Management and Budget. See 47 CFR § 54.600(b); United States Census Bureau, TIGER/Line Shapefiles, <https://www.census.gov/cgi-bin/geo/shapefiles/index.php> (last visited July 23, 2019) (Census Bureau CBSA Website). SHLB asserts that the maps in this Report and Order are not specific enough for a health care provider to identify whether it falls within an *Extremely Rural*, *Rural*, *Less Rural*, or *Non-Rural* tier. SHLB July 25, 2019 *Ex Parte* Letter at 3. The maps are provided for illustrative purposes. Program participants may identify the rural tier applicable to a particular health care provider site by: (1) going to the Census Bureau CBSA Website and downloading 2010 Core Based Statistical Areas, 2010 Urban Areas, and 2010 Tracts using the drop down menus; and (2) applying the data provided for the health care provider’s location to the *Extremely Rural*, *Rural*, *Less Rural*, and *Non-Rural* criteria. To facilitate that search process for health care providers, we direct the Wireline Competition Bureau to work with the Administrator to create a rural tier search tool accessible via the Administrator’s website.

change that introduces a new concept that may be needlessly complicated.<sup>91</sup> This approach also benefits from the ease with which the new rurality tiers can be employed to determine support.

34. In Alaska, several parties note the three rural tiers based on the existing definition of rural area may not adequately capture the state of comparable rural areas in the state.<sup>92</sup> Alaska is in a unique situation where most of the land mass is inaccessible by road.<sup>93</sup> Many communities are only accessible by plane or boat.<sup>94</sup> The barriers to providing telecommunications services to these off-road communities are thus typically higher than on-road communities even though by the population metrics used for the rural area tiers all would be similarly treated as falling in the Extremely Rural tier.<sup>95</sup> Grouping and treating all of these communities as comparable could thus significantly lower the rural rate determination through the inclusion of communities that simply do not face the same cost structure for the provision of telecommunications services as those conditions encountered in off-road communities. Accordingly, we find further bifurcating the Extremely Rural tier to include Frontier off-road areas necessary to ensure comparable rural areas for Alaska for the purpose of determining rural rates.

35. That said, we determine that such bifurcation must be based on an objective data source that—like United States Census Bureau data—enables program participants to identify whether a health care provider is in a Frontier or Extremely Rural location. Specifically, we accept the suggestion of ACS and others to treat areas outside of a Core Based Statistical Area that are inaccessible by road as a separate tier, i.e., Frontier areas.<sup>96</sup> Areas outside of a Core Based Statistical Area that are accessible by road will be treated as Extremely Rural for purposes of rate determination. To determine communities connected by roads, we will use the data provided by the Alaska Department of Commerce Community and Economic Development; Division of Community and Regional Affairs as suggested by ACS.<sup>97</sup> This

<sup>91</sup> See KSLLC Comments at 7 (opposing a definition that adds additional complexity). The rural contours that we adopt today, based on Core Based Statistical Area data, should result in precise determinations of rurality. We therefore do not agree with TeleQuality that segregating health care providers by degree of rurality will necessarily be a source of disputes. TeleQuality Comments at 15.

<sup>92</sup> See ACS July 24, 2019 *Ex Parte* Letter at 1-2; Alaska Primary Care July 24, 2019 *Ex Parte* Letter at 1; ANHB July 24, 2019 *Ex Parte* Letter at 1-2; ACS July 19, 2019 *Ex Parte* Letter at 2-3; GCI July 17, 2019 *Ex Parte* Letter at 2.

<sup>93</sup> While areas in other states and territories may have some locations inaccessible by road, the number of off-road communities in Alaska far exceed these other locales. Accordingly, we limit the use of Frontier areas to address the unique situation faced in Alaska and decline to apply a similar rurality tier in areas outside of Alaska. See, e.g., CHA July 22, 2019 *Ex Parte* Letter at 1 (noting the existence of off-road communities in Colorado).

<sup>94</sup> See ACS July 24, 2019 *Ex Parte* Letter at 1-2; Alaska Primary Care July 24, 2019 *Ex Parte* Letter at 1; ANHB July 24, 2019 *Ex Parte* Letter at 1-2; ACS July 19, 2019 *Ex Parte* Letter at 2-3; GCI July 17, 2019 *Ex Parte* Letter at 2.

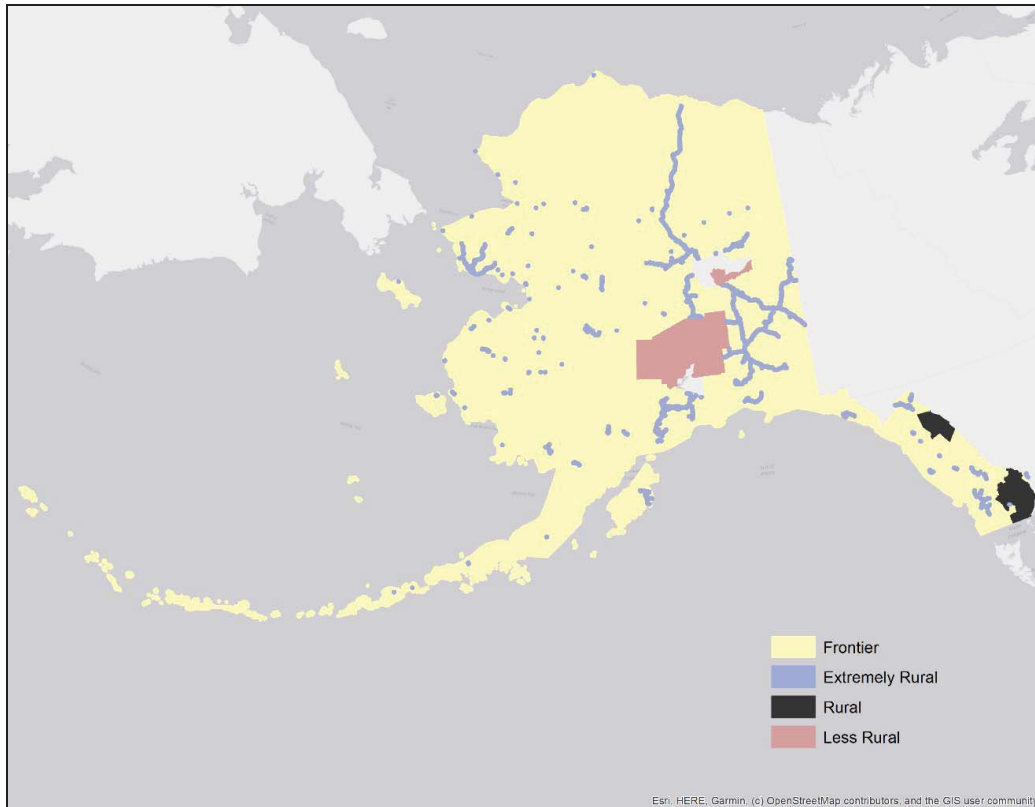
<sup>95</sup> *Id.*

<sup>96</sup> See ACS July 24, 2019 *Ex Parte* Letter at 1-2; APCA July 24, 2019 *Ex Parte* Letter at 1; ANHB July 24, 2019 *Ex Parte* Letter at 1-2.

<sup>97</sup> See Alaska Department of Commerce, Community, and Economic Development, Division of Community and Regional Affairs (Nov. 27, 2018), <https://dcra-cdo-dcced.opendata.arcgis.com/datasets/community-transportation-access-and-overview> (Alaska DoC Dataset); ACS July 25, 2019 *Ex Parte* Letter at 1-2. Off-road determinations based on the Alaska DoC Dataset will be made at the time that the Administrator performs its median rural rate determinations. See Part III.A.5. Those off-road determinations will apply until such time that the Administrator updates its median rural rate determinations (i.e., the Administrator will not be required to update off-road determinations from year-to-year unless part of an update to its rural rate determinations). ACS proposes that we permit health care providers to demonstrate that they are located in an off-road community even if that designation is not explicitly established by the Alaska DoC Dataset. ACS July 25, 2019 *Ex Parte* Letter at 2. We find that requiring the Administrator to engage in such case-by-case determinations would be inconsistent with our goal of  
(continued....)

data source will allow participants to determine the appropriate tier for the relevant health care provider and simplifies the administration of this aspect of the program. The following map illustrates the geographic boundaries of these four tiers in Alaska.

**Fig. 4: Map Showing the Four Tiers of Comparable Rural Areas in Alaska<sup>98</sup>**



36. We recognize that, even in Alaskan off-road communities, different levels of infrastructure may exist resulting in different costs for providing and obtaining services. GCI urges us to further sub-divide these off-road areas to capture these variances in service deployment.<sup>99</sup> GCI has failed

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adopting an objective, transparent, and administratively simple mechanism for establishing rural tiers for the purpose of rural rate determinations, and therefore reject that proposal.

<sup>98</sup> Note this map is for illustrative purposes only and does not reflect a final version of the boundaries for these rural tiers. Program participants in Alaska may determine whether or not a health care provider is located in a tier by looking up the health care provider's community on the *Alaska DoC Dataset* and contacting the Administrator. We direct the Wireline Competition Bureau to work with the Administrator to include this information in the rural tier tool it prepares for its website.

<sup>99</sup> See GCI First July 25, 2019 *Ex Parte* Letter at 2 (proposing grouping Extremely Rural Tier communities into four subcategories: road-system/fiber-served; off-road-system/fiber-served; off-road-system/terrestrially (non-fiber) served; and satellite-only served). See also GCI Second July 25, 2019 *Ex Parte* Letter at 7. Notably, one tier suggested by GCI seems to be designed to allow it to be the sole carrier offering terrestrial middle-mile service in the area—and thus the only carrier able to set the rates that would go into the rural rate calculation. Without the discipline of any competition (such as from terrestrial fiber), a carrier would have the perverse incentive to inflate middle-mile rates in order to game our tiering system and increase its support from the Universal Service Fund.



to provide a straight-forward, objective, and administratively simple measure for making such determinations, however. GCI proposes that the Administrator engage in case-by-case determinations of the rural tier applicable to health care providers in Alaska based on backbone network data reporting submitted to the Commission by participants in the Connect America Fund's Alaska Plan.<sup>100</sup> If additional information is needed to categorize communities that are not served by Alaska Plan participants, GCI suggests that the Commission somehow supplement the Alaska Plan backbone network data with information from a one-time data collection from other carriers.<sup>101</sup> In addition to being time-consuming and administratively burdensome, GCI's proposals would shield rural tier determinations from public scrutiny, given that backbone network data reported to the Commission is non-public and often submitted on a confidential basis.<sup>102</sup> Accordingly, to ensure that the process used to establish rural tiers is objective, administratively feasible, transparent, and simple to apply, we decline at this time to further sub-divide off-road communities for determining comparable rural areas pursuant to GCI's proposal.<sup>103</sup>

37. We expect that by broadening the scope of comparable rural areas used to compute the rural rate, we increase the likelihood of identifying available rates for the same or similar services within a state to determine rural rates, which addresses a concern raised by some commenters.<sup>104</sup> Moreover, because we now require consideration of available rates outside the health care provider applicant's immediate rural area (but within similarly tiered rural areas within the health care provider's state), the approach reflects a more faithful interpretation of the statutory obligation to reimburse carriers using rates for similar services provided to other customers in "comparable rural areas" in the state.<sup>105</sup>

### 3. Ensuring Reasonably Comparable Urban Rates

38. Based on the record and our past experience with the Telecom Program, we find that the current process for determining urban rates does not adequately advance the goals of the statute and requires reform. We revise our rules to require the Administrator to determine the urban rate based on a median<sup>106</sup> of available rates<sup>107</sup> for similar services across all urbanized areas in a state.<sup>108</sup> We also direct

<sup>100</sup> GCI First July 25, 2019 *Ex Parte* Letter at 2; GCI Second July 25, 2019 *Ex Parte* Letter at 7; see *Connect America Fund; Universal Service Reform—Mobility Fund; Connect America Fund—Alaska Plan*, WC Docket Nos. 10-90, *et al.*, Report and Order and Further Notice of Proposed Rulemaking, 31 FCC Rcd 10139, 10158, 10172, paras. 60, 102 (2016) (*Alaska Plan Order*). We note that carriers may seek an individualized determination on rural rates by satisfying the criteria in Part III.A.4.b.

<sup>101</sup> See GCI First July 25, 2019 *Ex Parte* Letter at 2.

<sup>102</sup> See *Connect America Fund—Alaska Plan*, WC Docket No. 16-271, Order on Reconsideration, 33 FCC Rcd 2068, 2082, Appx. (2018) (noting that data required to be submitted by Alaska Plan funding recipients is "likely to contain confidential data," establishing "an abbreviated means to allow submitters to request confidentiality," and stating that "[f]iling material for this data collection will be deemed to be a request under section 0.459 that the material not be made publicly available").

<sup>103</sup> We also note that further sub-dividing off-road communities could create disincentives for carriers to deploy fiber to areas that could potentially be made subject to a lower rural rate.

<sup>104</sup> See, e.g., GCI Public Comments at 21 ("[I]t can be difficult or impossible to find a sufficiently large pool of comparables to create a meaningful average, particularly in rural areas where populations are low and build-out is sparse.").

<sup>105</sup> See 47 U.S.C. § 254(h)(1)(A) ("A telecommunications carrier providing service under this paragraph shall be entitled to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in *comparable rural areas* in that State treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service.") (emphasis added).

<sup>106</sup> A median denotes the value lying at the midpoint of a range of values. For example, if there are seven same or functionally similar services with rates of \$70, \$85, \$95, \$100, \$120, \$280, and \$300, the median rate would be \$100. If there is an even number of rates for similar services, the median will be derived by taking the average of the middle pair of rates, adding them together, and dividing by two (i.e., if there are four rates of \$70, \$85, \$95,

(continued....)



the Administrator to create a publicly available database to post the urban rates for each state for program participants.<sup>109</sup> These changes will: (1) eliminate incentives by health care and service providers to manipulate the urban rate determination; (2) promote rate determination transparency and consistency; (3) provide health care providers with predictability on the urban rates prior to choosing among service offerings; and (4) decrease administrative burdens for rural health care providers participating in the Telecom Program.

39. In 1997, in fashioning the parameters of the Telecom Program, the Commission interpreted “reasonably comparable to rates charged for similar services in urban areas in that State” to mean the urban rate for a requested service could not exceed “the highest rate charged in the nearest large city.”<sup>110</sup> In adopting this approach, the Commission considered but rejected the use of an average rate.<sup>111</sup> The Commission found that basing the urban rate on the highest available rate in the nearest city was a more equitable way of determining the rate than using an average rate because, the Commission reasoned, the “use of average rates could result in pricing telecommunications services to rural health care providers at rates lower than those paid by many nearby customers.”<sup>112</sup>

40. In 2003, the Commission revisited the manner in which urban rates were determined.<sup>113</sup> At the time, rural health care provider participation in the RHC Program had not met the Commission’s initial projections.<sup>114</sup> The Commission decided to permit rural health care providers to use the urban rate “in any city with a population of at least 50,000 in the state, as opposed to the nearest city with a population of 50,000.”<sup>115</sup> According to the Commission, this would allow health care providers “to benefit from the *lowest* rates for services in the State.”<sup>116</sup> The Commission found the “public interest in providing more flexibility in utilizing telemedicine services and quality health care facilities outweigh[ed]

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\$100, the median would be  $(\$85 + \$95) \div 2 = \$90$ ). This is in contrast to an average, which is the “result you get by adding two or more amounts together and dividing the total by the number of amounts.” See Cambridge Dictionary, *Meaning of ‘average’ in English*, <https://dictionary.cambridge.org/us/dictionary/english/average> (last visited June 25, 2019). For the rates used in the first median rate example above, the average of those rates would be \$150.

<sup>107</sup> Available rates include tariff rates and rates posted on service providers’ websites, rate cards, and publicly available contracts such as state master contracts, as well as undiscounted rates charged to E-Rate Program applicants, prior funding year RHC Program pricing data, and National Exchange Carrier tariff rates. This list of possible sources of available rates is not intended to be exhaustive. Other sources may be possible. As is currently the case, any rates reduced by universal service support mechanisms may not be used to determine the rural rate, though the undiscounted versions of those rates may be.

<sup>108</sup> Urbanized areas are designated by the Census Bureau and are “continuously built-up area[s] with a population of 50,000 or more” and comprising of “one or more places—central place(s)—and the adjacent densely settled surrounding area—urban fringe—consisting of other places and nonplace territory.” Census Bureau, *The Urban and Rural Classifications* at 12-1, available at <https://www2.census.gov/geo/pdfs/reference/GARM/Ch12GARM.pdf>. Based on the 2010 Census, there are 486 urbanized areas nationwide. Press Release, Census Bureau, Growth in Urban Population Outpaces Rest of Nation, Census Bureau Reports (Mar. 26, 2012), [https://www.census.gov/newsroom/releases/archives/2010\\_census/cb12-50.html](https://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html).

<sup>109</sup> The creation of the database is discussed in more detail in Part III.A.5.

<sup>110</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 350, para. 669.

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 350-51, para. 670.

<sup>113</sup> *2003 RHC Internet Access Order*, 18 FCC Rcd at 24565, para. 37.

<sup>114</sup> *Id.* at 24547, para. 1.

<sup>115</sup> *Id.* at 24565, para. 37 (emphasis added).

<sup>116</sup> *Id.* (emphasis added).

any minimal advantage gained by rural health care providers” who may obtain a rate lower than certain health care providers in urban areas.<sup>117</sup>

41. The Commission’s rules currently place a ceiling on the amount a health care provider is required to pay for a requested service, stating the urban rate “shall be a rate no higher than the highest publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state.”<sup>118</sup> The urban rate is determined by the health care provider, often with the assistance of a consultant or carrier, and reported on the FCC Form 466.<sup>119</sup> The form’s instructions direct the health care provider to document the urban rate reported. The supporting “[d]ocumentation may include tariff pages, contracts, a letter on company letterhead from the urban service provider, rate pricing information printed from the urban service provider’s website or similar documentation showing how the urban rate was obtained.”<sup>120</sup> Alternatively, the applicant may use, without any additional documentation, the “safe harbor” urban rate listed for a limited number of services in certain states on the Administrator’s website.<sup>121</sup> These safe harbor urban rates were determined by the Administrator after reviewing tariff information on file with the Commission.

42. The current process for determining urban rates contributes to the inefficient increase in support demand. As the data show, health care providers are increasingly paying less and less for eligible services. For example, the Telecom Program commitments increased in size by more than 80% from approximately \$116 million in funding year 2012 to approximately \$211 million in funding year 2016.<sup>122</sup> Gross demand for Telecom Program requests respectively totaled approximately \$272 million and \$206 million for funding years 2017 and 2018.<sup>123</sup> The overall out-of-pocket expenses for health care providers, however, have decreased from approximately \$23 million in funding year 2012 to approximately \$12 million in funding year 2017.<sup>124</sup> The overall effective discount rate thus rose steadily during this period to

<sup>117</sup> *Id.*

<sup>118</sup> 47 CFR § 54.605(a); *Universal Service First Report and Order*, 12 FCC Rcd at 350, para. 669 (a reasonably comparable rate in the urban rate context means a rate no higher than the highest rate charged in the nearest city); *2003 RHC Internet Access Order*, 18 FCC Rcd at 24565, para. 37 (extending the rate comparison to *any* city within the state to “allow rural health care providers to benefit from the lowest rates for services in the State); FCC Form 466 Instructions (the rural health care provider may document and use an urban rate that is lower than the “safe harbor” rate on the Administrator’s website).

<sup>119</sup> See FCC Form 466 Instructions, Block 6. The determination of urban rate is heavily dependent on the functionally similar services in a city identified by the applicant. The instructions to the FCC Form 466 provide applicants with guidance on what is considered a functionally similar service. See *id.* at 6-7. This guidance is based on the Commission’s prior statements in a 2003 Report and Order. *2003 RHC Internet Access Order* at 24563-64, para. 33. In Part III.A.1, we separately address the interpretation of “similar services” for determining urban and rural rates.

<sup>120</sup> See FCC Form 466 Instructions, at 8.

<sup>121</sup> See *id.* at 8; USAC, *Urban Rates Search*, <https://www.usac.org/rhc/telecommunications/tools/UrbanRates/search.asp> (last visited May 31, 2019). The services for which urban rates are provided on the Administrator’s website are limited to DS3 (45 Mbps month-to-month), T-1 (1.544 Mbps month-to-month), and voice grade service (single termination). *Id.* The urban rates database does not include rates for all states, e.g., no rates identified for Alaska. *Id.* The urban rate reported by the health care provider can be lower than the “safe harbor” rate listed on the Administrator’s website provided there is sufficient documentation to support the lower rate. See FCC Form 466 and Instructions, Block 6.

<sup>122</sup> See *infra* Fig. 5 (showing original commitments for the Telecom Program compared to total amounts paid by all health care providers for services). While Figure 5 indicates commitments declined to \$155 million in funding year 2017, the total does not reflect the total amount of all outstanding requests for that funding year, which total about \$25 million. *USAC Data Submission* at Appx. A, p. 2.

<sup>123</sup> See *supra* Fig. 2.

<sup>124</sup> See *infra* Fig. 5.

92% in funding year 2017, meaning health care providers were collectively paying only 8% of the total cost of the service.<sup>125</sup> In many cases, individual health care providers paid as little as 1% or less for the services they received.<sup>126</sup> In funding year 2016, 5% of participating health care providers in the Telecom Program received 62% of the committed funding, i.e., \$131 million, with an effective discount rate of 99% and above.<sup>127</sup> As a result, health care providers increasingly have less incentive, because they have increasingly less money invested, to cost-effectively obtain services to minimize strain on the Universal Service Fund.<sup>128</sup>

**Fig. 5: Telecom Program Commitments and Health Care Provider Expense<sup>129</sup>**



43. We are also concerned that urban rates submitted on the Telecom Program's request for funding form (FCC Form 466) are being held artificially low and may not reflect the comparable urban rates charged for services in urban areas. For example, after comparing available information for the E-Rate Program, the median rates reported by rural health care providers are in many cases far less than the

<sup>125</sup> Effective discount rate means the percentage discount health care providers are receiving as compared to the overall cost of the services (i.e., the total original commitments for a funding year divided by the total out-of-pocket expenses plus the total original commitments). See *infra* Fig. 5.

<sup>126</sup> See 2017 Promoting Telehealth Notice and Order, 32 FCC Rcd at 10639, para. 10, Fig. 3 (showing Telecom Program funding distribution among health care providers by discount rate).

<sup>127</sup> See *id.*; USAC Data Submission at Appx. A, p. 3.

<sup>128</sup> See 2017 Promoting Telehealth Notice and Order, 32 FCC Rcd at 10639, para. 9, Fig. 2 (showing out-of-pocket expenses decreasing from \$40 million in funding year 2011 to \$11 million in funding year 2016).

<sup>129</sup> Monetary amounts shown are in millions. Figure 5 is based on data reported to and maintained by the Administrator. See USAC May 31, 2019 Commitment Data Spreadsheet.

median rates paid by schools and libraries in urbanized areas of the state for the same or similar services.<sup>130</sup>

**Table 1: Telecom Program (TP) Urban Rates vs. Rates Charged to Schools and Libraries (SL)<sup>131</sup>**

Monthly Recurring Rates for T1/DS1 1.544 Mbps						
State	TP Min.	TP Max.	Median		SL Min.	SL Max. Median
AZ	\$34.77	\$284.67	\$97.16		\$350	\$1639.24 \$350
CA	\$37.99	\$266.39	\$109.38		\$21.95	\$1630.98 \$155.55
GA	\$70.01	\$72	\$70.01		\$246	\$1320 \$695
TX	\$18.98	\$277.88	\$66.36		\$43.64	\$4611.78 \$292.04
WI	\$29.84	\$138.63	\$85.47		\$118.56	\$325 \$325
Monthly Recurring Rates for Ethernet 10 Mbps						
State	TP Min.	TP Max.	Median		SL Min.	SL Max. Median
CA	\$95	\$775.63	\$191.89		\$42.5	\$3997.86 \$500
GA	\$129	\$279.68	\$250		\$495	\$1490 \$660
MI	\$80.89	\$231.56	\$101.65		\$82	\$1816.26 \$589.68
TX	\$214.50	\$276	\$237.25		\$100	\$1666.98 \$636.37
VA	\$125	\$276	\$175		\$598	\$1200 \$675
Monthly Recurring Rates for Ethernet 100 Mbps						
State	TP Min.	TP Max.	Median		SL Min.	SL Max. Median
AZ	\$260	\$1200	\$276		\$50	\$5016 \$977.50
CA	\$79.85	\$1052.81	\$315.61		\$69	\$18850 \$774.91
GA	\$245	\$648.44	\$245		\$133	\$5641.97 \$760.88
TX	\$276	\$1730.26	\$276		\$50.6	\$9096.06 \$500
WI	\$166.72	\$563.40	\$267.62		\$79.99	\$10788 \$642.50

44. We observe similar differences when comparing the median rates in Alaska. The large majority of services for which Telecom Program funding is sought in Alaska falls into the category of satellite services and Multiprotocol Label Switching (MPLS). The Commission allows for the determination of an urban rate for satellite services based on rates available for non-satellite services.<sup>132</sup> Accordingly, while E-Rate Program recipients in the only urbanized area in Alaska, Anchorage, do not typically seek funding for satellite services, we find instructive the rates paid for those terrestrial services in Anchorage with the same broadband speeds as the corresponding satellite service.

<sup>130</sup> See Tbl. 1.

<sup>131</sup> This Table is based on a review of funding year 2017 data for the both the RHC Program for rural health care providers and the monthly recurring rates charged to schools and libraries in urbanized areas in the E-Rate program. See *RHC Program Open Data Platform*; USAC, *USAC Open Data, E-Rate*, <https://opendata.usac.org/browse?category=E-rate&limitTo=datasets> (*E-Rate Program Open Data Platform*) (last visited July 5, 2019).

<sup>132</sup> See 47 CFR § 54.609(d); 2003 *RHC Internet Access Order*, 18 FCC Rcd at 24568, paras. 43-44.

**Table 2: Telecom Program (TP) Urban Rates vs. Rates Charged to Schools and Libraries (SL) in Alaska<sup>133</sup>**

Service Type	Bandwidth	TP Min.	TP Max	Median
Satellite	10 Mbps	\$200	\$300	\$200
MPLS	10 Mbps	\$200	\$300	\$300
MPLS	100 Mbps	\$638	\$700	\$680
Service Type	Bandwidth	SL Min.	SL Max	Median
Ethernet	10 Mbps	\$416.63	\$416.63	\$416.63
Ethernet	100 Mbps	\$750	\$1635	\$933.33
MPLS	100 Mbps	\$625	\$10700	\$947.50

45. In the *2017 Promoting Telehealth Notice and Order*, the Commission sought comment on ways to reform the urban rate determination—specifically, ways to eliminate urban rate cherry-picking and ensure that the urban rate used to compute Telecom Program commitments are comparable to the rates charged for same or similar services in urban areas.<sup>134</sup> The Commission also sought comment on whether rate averaging would eliminate the incentive to essentially cherry-pick the lowest rate in the state.<sup>135</sup> The Commission also asked whether, in lieu of rate averaging, it should adopt a median-based approach to minimize the effect of very high and low rates which could skew an average rate.<sup>136</sup> The Commission then sought comment on whether the Administrator should collect and publicize the urban (as well as rural) rate data instead of requiring the rural health care provider, who may have an incentive to use rates that are not representative of typical urban rates, to provide the information.<sup>137</sup> To remove concerns about misguided incentives and provide greater transparency, the Commission specifically proposed that the Administrator collect and aggregate the prior year's Telecom Program and E-Rate Program data, as well as available rate data for the urban rate and post this data on its website for use by the rural health care provider and its carrier.<sup>138</sup> Commenters generally supported modifying the current urban rate rule to use an average of the cost of service in urban areas.<sup>139</sup> Several commenters supported having the Administrator determine the urban rates.<sup>140</sup>

46. Accurately determining the urban rate is imperative to the integrity of the Telecom Program. The urban rate is not only key to incentivizing health care providers to make service choices in a cost-efficient manner but is also critical to determining the level of universal service support provided to participants. The dramatic increase in funding commitments in the Telecom Program combined with declining urban rates requires the Commission to carefully reevaluate our current procedures for

<sup>133</sup> This chart is based on a review of funding year 2017 data for both the RHC Program for rural health care providers and the E-Rate Program for schools and libraries. See *RHC Program Open Data Platform*; *E-Rate Program Open Data Platform*.

<sup>134</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10653, para. 67.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.* at 10654-55, para. 72.

<sup>137</sup> *Id.* at 10653-54, paras. 68-69 (explaining that, by providing rate information, a service provider is the entity with the most to gain financially and may have incentives that are not aligned with the Telecom Program goals of efficiency and transparency).

<sup>138</sup> *Id.* at 10654, para. 69.

<sup>139</sup> ADS Reply Comments at 3; ADS Reply Comments at 1 (based on largest 25 Metropolitan Service Areas); SpaceX Comments at 4 (average rate for functionally similar service in city of 50,000 or more); ACS Comments at 28-9; TeleQuality Reply Comments at 4.

<sup>140</sup> See ACS Comments at 28; NRHA Comments at 1; ADTRAN Comments at 7; TeleQuality Comments at 12.

determining the urban rate.<sup>141</sup> We must ensure the limited available funding is efficiently allocated in a specific and predictable manner to further the goals of the statute for as many rural health care providers as possible. Based on our review of the record and program data, we find the existing approach for determining urban rates is not producing reasonably comparable urban rates and requires reform to reflect the rates actually being charged in urban areas of the state more accurately than the current methodology. We are also concerned the current methodology fails to provide adequate incentives for health care providers to act in the best interests of the Universal Service Fund and is susceptible to rate manipulation.<sup>142</sup> We therefore find reforming the urban rate determination necessary to further the intent of Congress of ensuring that rural health care providers are placed on equal footing with their urban counterparts, and to preserve and advance the Universal Service Fund.<sup>143</sup>

47. To this end, we now change course and require that the Administrator calculate urban rates based on the available rates, including data available from the E-Rate Open Data Platform,<sup>144</sup> for functionally similar services offered across all urbanized areas of the state.<sup>145</sup> We find this approach will more likely produce a reasonably comparable urban rate than the current approach by taking into account a wider range of urban rates. In addition, we require the Administrator to determine the urban rate by using the median of the available rates for functionally similar services. There are multiple sources of

<sup>141</sup> See *supra* Fig. 1 (showing original commitments for funding years 2012-2017); Fig. 5 (showing out-of-pocket expenses for health care providers for funding years 2012-2017).

<sup>142</sup> We thus agree with AT&T that the current rules “encourage[] the use of consultants or service providers which have made it easy for unscrupulous parties to create artificially low urban rates . . . , which feeds skyrocketing growth in the Program.” AT&T Public Notice Comments at 1-4.

<sup>143</sup> See 47 U.S.C. §§ 254(b)(5), (h)(1).

<sup>144</sup> GCI asserts without persuasive evidence that the E-Rate Open Data Platform does not accurately identify the services actually being provided to E-Rate customers. See GCI July 17, 2019 *Ex Parte* Letter at 3; GCI July 23, 2019 *Ex Parte* Letter at 4. We reject this contention. The E-Rate Open Data Platform is populated with data submitted by schools and libraries on their FCC Form 471 funding applications for the E-Rate Program. See *E-Rate Open Data Platform, E-rate Request for Discount on Services: Connectivity Information (FCC Form 471 and Related Information)*, <https://opendata.usac.org/E-rate/E-rate-Request-for-Discount-on-Services-Connectivi/ym44-rnhq> (last visited July 29, 2019). As in the RHC Program, the Administrator issues E-Rate Program funding decisions based on the service information submitted in those applications. Funding commitment decision letters (FCDL) are sent to both the applicant and the service provider. In addition to the amount of funding approved, FCDLs specify the services for which the Administrator has approved the funding and the service provider that has been authorized to provide those services. See USAC, FCC Form 474 (SPI) User Guide (April 2017), <https://www.usac.org/res/documents/sl/pdf/forms/FCC-Form-474-UserGuide.pdf>. After the approved services have been provided, either the applicant or the service provider may submit invoices for funding disbursements. USAC, Schools and Libraries Program, Step 5 Invoicing (March 2019), <https://www.usac.org/sl/service-providers/step05/default.aspx>; 47 CFR § 54.514. Before a service provider can submit an invoice, however, it is required to certify, among other things, that the invoices it submits seek E-Rate disbursements “for services which have been billed to the Service Provider’s customers on behalf of schools, libraries, and consortia of those entities, as deemed eligible for universal service support by the fund administrator,” and that the services for which the invoices are submitted are for services deemed eligible for universal service support by the Administrator. See USAC, FCC Form 473 User Guide (April 2017), <https://www.usac.org/res/documents/sl/pdf/forms/FCC-Form-473-UserGuide.pdf>; see also 47 CFR § 54.504(f). Accordingly, any service provider that has submitted an invoice for E-Rate Program funding has done so pursuant to certifications that any resulting disbursement it receives is for services as approved by the Administrator (i.e., the services identified in the FCDL pursuant to the FCC Form 471 filed by the school or library). GCI’s argument is, therefore, tantamount to an assertion that E-Rate funds have been improperly disbursed to service providers for unapproved services, which would be properly addressed through a compliance audit or investigation, not questions about the reliability of the E-Rate Open Data Platform. Further, GCI contradicts its own arguments in a later letter, asserting that it would be arbitrary and capricious to not consider E-Rate rate information in rural rate determinations. GCI July 29, 2019 *Ex Parte* Reply Letter at 4.

<sup>145</sup> See 47 CFR § 54.604(a) as adopted herein; Appx. A, Final Rules.



information on rates for the Administrator to review and analyze. The Administrator is moreover likely better positioned to identify these rates than small health care providers who likely have limited resources and are unfamiliar with the telecommunications industry. Having the Administrator conduct the rate determination, as opposed to the health care provider, will further eliminate any potential incentives to manipulate rates and will provide transparency and predictability to the rate determination process as well as ease burdens on health care providers.

48. We will no longer allow health care providers to determine the urban rate from the rates available in any particular city in the state. In 2003, the Commission expanded the geographical boundaries from which urban rates could be considered from the nearest city with a population of 50,000 or more to any such city in the state with the goal that rural health care providers “benefit from the lowest rates for service in the State.”<sup>146</sup> The Commission reasoned the largest cities in a state likely have significantly lower rates and more service options than the city nearest to the rural health care provider with a population of least 50,000.<sup>147</sup> We now conclude that this approach goes beyond the intent of Congress of providing “reasonably comparable” urban rates to rural health care providers and leads to funding inefficiencies. This approach is no longer tenable given the growing demand for program funding.

49. The median urban rate for a particular service will be the sole urban rate that a health care provider may use on its FCC Form 466 application to request Telecom Program support.<sup>148</sup> We use the median here rather than an average notwithstanding comments filed supporting the latter.<sup>149</sup> SpaceX notes that an average rate would provide “an objective and independently verifiable standard.”<sup>150</sup> We agree that using multiple price points to determine the urban rate will bring restraint and discipline to the Program and will minimize opportunities for rate manipulation. We are concerned, however, with using an average because rates may be skewed by a very high or very low rate for that service in some location. For example, in Texas for funding year 2017, health care providers reported on the FCC Form 466 urban

<sup>146</sup> 2003 RHC Internet Access Order, 18 FCC Rcd at 24565, para. 37.

<sup>147</sup> *Id.* at 24565, para. 36.

<sup>148</sup> Several commenters suggest that health care providers pay a percentage of the urban-rural differential to help ensure cost-effective purchases, *see, e.g.*, SHLB Jan. 30, 2019 Comments at 7; TeleQuality Comments at 8; GCI Jan. 30, 2019 Comments at 32; GCI Feb. 13, 2019 Comments at 9-10. In its July 23, 2019 *Ex Parte* Letter, GCI proposes that health care providers pay a gradually phased-in minimum copayment that starts at 1% and increases to 5% over five years. *See* GCI July 23, 2019 *Ex Parte* Letter at 4-5. GCI asserts that requiring health care providers to pay more for Telecom Program services than the comparable urban rate will help add discipline to the health care providers’ procurement choices. *Id.* Many commenters opposed any proposal to charge health care providers a percentage of the differential in addition to the urban rate. *See* ACS Reply Comments at 9 (“Nor should the Commission — contrary to Section 254 of the Act — require any rural health care providers to make minimum payments in excess of reasonably comparable urban rates.”); ANHB Comments at 7 (“[T]he GCI proposal is not a modest increase in the costs paid by the HCPs, but would increase the costs for many rural HCPs in Alaska by 500% over 5 years, equivalent to paying 5 times the urban rate.”); Maniilaq Association Comments at 6; Bristol Bay Comments at 9; Norton Sound Comments at 8. We agree with these commenters and find requiring rural health care providers to pay more than the urban rate even when funds are available to pay the differential is inconsistent with the goal of section 254 that ensures rural health care providers pay rates for telecommunications services that are comparable to their urban counterparts and is not in the public interest. We therefore do not need to consider further GCI’s argument that the Commission should issue a limited forbearance of its urban rate rule pursuant to section 10(b) of the Communications Act to allow for its proposal to be implemented. *See* GCI Second July 25, 2019 *Ex Parte* Letter at 2.

<sup>149</sup> *See, e.g.*, SpaceX Comments at 4-5 (USAC should set urban and rural rates based on average rates charged for services in urban and rural areas); ADS Comments at 3 (recommending that the urban rates be the average cost of service in the largest 25 Metropolitan Service Areas); ACS Public Notice Comments at 15-17 (the Administrator should set the urban rate based on an average of publicly available rates).

<sup>150</sup> SpaceX Comments at 4.

rates for voice grade business circuits ranging from about \$938 to \$9 at the high and low ends but with a large majority of the urban rates falling in the \$40 to \$400 range.<sup>151</sup> The high and low rates in this scenario could skew the average upwards or downwards depending on the other rates in the data set whereas a median mutes these potential outliers. The potential for intentionally manipulating the urban rate determination, by interjecting available outlier rates, is thus lessened.

50. We note a few commenters oppose averaging to determine rates, raising concerns over the practicality of identifying available rates and the ability of such a process to produce reasonably comparable urban rates as required by the statute.<sup>152</sup> We expect these concerns would apply equally to a median-based approach but find that directing the Administrator rather than Telecom Program participants to collect urban rate data, and to collect such data on a statewide basis, mitigates those concerns. Accordingly, we disagree with these commenters on the viability of the approach adopted here to produce reasonably comparable urban rates.<sup>153</sup>

51. *Eliminate “No Higher Than” Standard.* In moving to a median urban rate determination conducted by the Administrator, we eliminate the “no higher than the highest publicly available rate” restriction on the urban rate determination. In practice, this existing ceiling has no effect as a health care provider would be unlikely to ever determine and report an urban rate that is higher than the highest available rate in any city in the state. Moreover, the median urban rate we adopt is by definition a rate that is no higher than the highest available rate. Accordingly, we eliminate the “no higher than” restriction and instead require health care providers to use the median urban rate identified by the Administrator for the relevant eligible service when submitting FCC Form 466 filings.

52. *Eliminate the Standard Urban Distance.* We eliminate the standard urban distance demarcation contained in our current urban rate rule.<sup>154</sup> The current rule provides two methods for determining the urban rate depending on whether the requested service is provided over a distance that is either less than or equal to, or else greater than the “standard urban distance.”<sup>155</sup> The “standard urban distance” for a state is the “average of the longest diameters of all cities with a population of 50,000 or more within the state.”<sup>156</sup> Based on our current rules, a rural health care provider’s rate for services provided over a distance greater than the standard urban distance would be no greater than the urban rate for services provided over the standard urban distance, while the rate for services provided at a distance equal to or less than the standard urban distance would be equal to the urban rate for services provided

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<sup>151</sup> *RHC Program Open Data Platform.*

<sup>152</sup> See GCI Public Notice Comments (averaging publicly available rates is as a practical matter impossible because of the lack of public information). SHLB Public Notice Comments at 3 (stating that “[d]etermining rates based on an average of publicly available rates may not be consistent with Congress’ intent” of enabling “access [to] telecommunications services at prices that are ‘reasonably comparable’ to their urban counterparts”); YKHC Reply Comments at 10 (“[A] miscalculation of ‘acceptable’ rates by the Commission, for example by averaging rates across disparate geographies and densities, could conflict with the RHC Program’s ability to fulfill its statutory mandate of making services available to rural health care providers at rates reasonably comparable to those paid by urban providers.”).

<sup>153</sup> Additional details about the Administrator’s procedures for determining and making urban rates publicly available are provided in Part III.A.5.

<sup>154</sup> This distance-based demarcation for determining urban rates is separate and apart from the issue of providing distance-based support that is addressed in Part III.A.7.

<sup>155</sup> 47 CFR § 54.605(b) (providing that “[i]f a rural health care provider requests an eligible service to be provided over a distance that is greater than the ‘standard urban distance,’ . . . the urban rate for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service provided over the standard urban distance in any city” with at least 50,000 people).

<sup>156</sup> 47 CFR § 54.605(c).

over the actual distance to be covered.<sup>157</sup> Because the urban rate we adopt is determined using rate data from all urbanized areas in the state, we believe it will reflect a reasonably comparable rate for the particular service regardless of the distance actually covered, and as a result, a distance measure is no longer relevant.

#### 4. Reforming the Determination of Rural Rates

53. To simplify rural rate determinations, encourage transparency and predictability, and minimize the risk of rate manipulation, we reform the framework for determining rural rates. Specifically, we revise our rules to establish a single method for determining the rural rate, which will be the median of all available rates charged for the same or functionally similar service in the rural tier where the health care provider is located within the state. We also direct the Administrator to determine the rural rate for each eligible service and rural tier in each state and publish the rural rates in a publicly available database. We further establish a standard of review for carriers that wish to seek a waiver of a rural rate determined pursuant to these steps that requires a demonstration that the carrier will be unable to recover its economically reasonable costs of supplying service, as defined below, if it is limited to the rural rates determined by the Administrator.

54. The Commission's rules currently permit three methods for calculating the rural rate depending on each health care provider's situation: (1) averaging the rates that the carrier actually charges to non-health care provider commercial customers for the same or similar services provided in the rural area where the health care provider is located; (2) averaging publicly available rates charged by other service providers for the same or similar services over the same distance in the rural area where the health care provider is located (applicable in cases where the service provider does not provide service to the health care provider's rural area); or (3) requesting approval of a cost-based rate from the Commission (for interstate services) or a state commission (for intrastate services) if there are no rates for same or similar services in that rural area or the carrier believes the calculated rural rate is unfair.<sup>158</sup> Applicants must justify the rural rate calculation on which they rely when seeking Telecom Program support by using one of these three methods.

55. Like the urban rate, the rural rate has proven to be difficult for health care and service providers to calculate and is susceptible to manipulation. The National Rural Health Association explains that determining the rural rate requires a level of "relevant expertise" that most health care providers lack, which "all but ensures that they cannot complete their application without outside assistance, creating a further barrier for the most disadvantaged applicants."<sup>159</sup> AT&T likewise criticizes the existing rural rate rules as being "far too complicated for an applicant – a rural health care provider in the business of providing essential health care services to underserved populations – to perform."<sup>160</sup> The complexity of the rural rate rules has caused health care providers to frequently rely on consultants or their service providers to navigate the rules, which AT&T observes has "made it easy for unscrupulous parties to create artificially high 'rural rates,' and, in some cases, artificially low 'urban rates' thus maximizing the alleged disparity between rural and urban rates."<sup>161</sup>

56. We agree that the existing rural rate rules are overly complicated and prone to abuse. Indeed, the risk of artificially inflated rural rates is very real under our existing framework. When a carrier sets the rural rate by averaging the rates of identical or similar services, the service rates of other carriers are not considered by design (in cases where the carrier offers commercial service to the health

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<sup>157</sup> 47 CFR § 54.605.

<sup>158</sup> 47 CFR § 54.607.

<sup>159</sup> NRHA Comments at 4.

<sup>160</sup> AT&T Public Notice Comments at 1.

<sup>161</sup> *Id.*

care provider's rural location) or may not be considered by selective omission (in cases where the carrier does not offer commercial service to the health care provider's location). Either way, the lack of consideration of competitors' offerings can lead to a rural rate that does not reflect the true rate of service available at the health care provider's location and which can be manipulated upwards because the service provider is incentivized to do so. In each of the foregoing examples, health care providers have no countervailing incentive to check carrier pricing because they pay only the lower urban rate without regard to the rural rate.

57. It is a matter of record that rural rates are rising sharply, as reflected in the increasing combined levels of Telecom Program funding commitments over the past several years.<sup>162</sup> The aggregate rural rate in 2004, for example, was \$42 million.<sup>163</sup> That aggregate figure climbed steadily over the next seven years to \$142 million by funding year 2011, and then increased again by \$80 million over the next five years to \$222 million.<sup>164</sup> The rural rate is not only increasing in the aggregate, it is increasing on an individual basis as well. Between funding year 2011 and funding year 2016, as the rural rate increased in the aggregate by \$80 million, the number of health care provider sites requesting support decreased by 30%.<sup>165</sup> These numbers equate to an average rural rate (per individual health care provider site) that more than doubled from \$37,755 in 2011 to \$84,797 in 2016.

58. Although some of the increase in the rural rate can be attributed to legitimate causes such as a health care provider's location, demand for and availability of higher speed services, and limited access to high speed middle-mile transport capacity,<sup>166</sup> that appears to be only part of the story. Given the widely divergent rates for same services we have seen (recall that in Tulare County, California, rural rates for 10 Mbps Ethernet service ranged from \$420 a month to \$4,308 a month),<sup>167</sup> it appears much of the increase results from the lack of adequate transparency, standardization, and enforceability in the existing method of determining rural rates, collectively opening the door to rate manipulation. The Administrator currently must examine each funding request individually to determine if the associated rural rate was properly calculated and substantiated, and whether the substantiated rate complies with the requirements under our rules.<sup>168</sup> This task requires access either to all of the service providers' rates or to available rates for the applicable rural area. Because this information is not readily available to the Administrator in-house, it has come to rely on rate data provided by the very parties, namely carriers, with the greatest interest in keeping rural rates high. This can lead to rural rates inconsistently calculated, artificially inflated, and difficult to verify against public data sources. It also results in review process delays that understandably tax the patience of RHC Program participants waiting for final support determinations and

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<sup>162</sup> See *supra* Fig. 5. The rural rate is equal to the total commitment amount plus the health care provider's out-of-pocket expenses (i.e., the urban rate).

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> See Fig. 5 and *USAC Data Submission* at Appx. A, p. 6. We note that rural rates decreased during funding year 2017. This reversal in the trend towards increased rates is attributable in large measure to the heightened scrutiny of funding requests undertaken by the Administrator and the Wireline Competition Bureau following enforcement investigations that revealed efforts by prominent telecommunications carriers to inflate rural rates. See *supra* note 39.

<sup>166</sup> See ACS Comments at 23.

<sup>167</sup> See *supra* para. 12.

<sup>168</sup> See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 30 FCC Rcd 230 (WCB 2015); see also USAC, *Review, Approve, Submit*, <https://www.usac.org/rhc/telecommunications/health-care-providers/step05/default.aspx> (last visited June 26, 2019) (USAC "reviews and approves the submitted FCC Form 466 and supporting documentation.").

funding commitments.<sup>169</sup> Inefficiency and waste of this type is especially problematic now given the extreme demands on limited RHC Program funds. For these reasons, we are compelled to make the programmatic changes to the rural rate rules.

**a. Modifying the Rural Rate Calculation**

59. The Commission's rules require health care and service providers to justify the requested rural rate by using one of three methods that require, depending on the circumstances, either averaging rates offered by the service provider, averaging rates offered by carriers other than the service provider, or conducting a cost-based analysis.<sup>170</sup> In the *2017 Promoting Telehealth Notice and Order*, and in the subsequent Public Notice seeking to refresh the record, we sought comment on methods of determining the rural rate to minimize potential variances in and manipulations of rates.<sup>171</sup> We specifically proposed using the average of all available rates charged for the same or similar services in the rural area in which the health care provider is located.<sup>172</sup> We also asked whether, in lieu of rate-averaging, a median-based approach should be adopted and whether the cost-based method of determining rural rates approach was still necessary.<sup>173</sup>

60. We adopt a new method of calculating rural rates, applicable in all cases, to be applied and publicly maintained by the Administrator. The rural rate will be the median of available rates for the same or similar services offered within the health care provider's rural tier (i.e., Extremely Rural, Rural, or Less Rural) in the state.<sup>174</sup> For example, the maximum rural rate for a particular service requested by a health care provider located in an Extremely Rural area would be the median rate charged for that same or similar service in all areas within the health care provider's state that are deemed Extremely Rural.

61. As with the median urban rate, the relevant rates to be used when determining the median rural rate will be broadly inclusive and comprised of the service provider's own available rates to other non-health care providers, as well as other available rates in the rural area, including rates posted on service providers' websites, rate cards, contracts such as state master contracts, undiscounted rates charged to E-Rate Program applicants, prior funding year RHC Program pricing data, and National Exchange Carrier Association (NECA) tariff rates.<sup>175</sup> In the unlikely event that a health care provider's rural tier includes no available rates for a particular service, we direct the Administrator to use the available rates for that service available from the tier next lowest in rurality in the health care provider's state (i.e., the Administrator will use the rates from the Rural tier if no rates are available in the Extremely Rural tier, and from the Less Rural tier if no rates are available in the Rural tier).

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<sup>169</sup> See ACS Comments at 39 (“[D]elay and uncertainty are unacceptable for many healthcare providers, especially those small, non-profit entities with no ability to raise additional funds should USAC fail to deliver the expected RHC support for a year that is quickly expiring.”). Several commenters urge the Commission to adopt “any” procedural improvements that will reduce the time it takes the Administrator to issue funding commitment decisions. See, e.g., ANTCH Comments at 10; BBAHC Comments at 11; Maniilaq Comments at 7; NSHC Comments at 9.

<sup>170</sup> 47 CFR § 54.607.

<sup>171</sup> *2018 Refresh Public Notice*, 33 FCC Rcd at 11708-09; *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10651-53, paras. 61-66.

<sup>172</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10652, para. 64.

<sup>173</sup> *Id.* at 10653-55, paras. 66, 72.

<sup>174</sup> See 47 CFR § 54.605(a), as adopted herein; Appx. A, Final Rules. A “rate” under our new approach continues to mean a single rate for complete end-to-end service. See *Universal Service First Report and Order*, 12 FCC Rcd at 9128, paras. 674-75.

<sup>175</sup> This list of possible sources of available rates is not intended to be exhaustive.

62. The new standardized approach to determining the rural rate will eliminate the problem of rate inconsistency that results from our current method. For example, three rural health care providers in Alamosa, Colorado, requested support for T1 service for funding year 2017. These health care providers, located within less than two miles of each other, included rural rates of \$294.24, \$827.00, and \$2,077.65.<sup>176</sup> Discrepancies such as these arise under the existing rate-setting framework because health care and service providers are left to their own devices to select the data required to make rate determinations for each funding request and would have to conduct exhaustive research on their own to ensure that the data is comprehensive. Indeed, because any number of variables can affect rates for the same service offering, health care and service providers have had to grapple with an inconsistent process that lacks the controls, transparency, and predictability necessary to ensure a fair and reliable allocation of scarce Telecom Program funds. Simply put, analyses of different datasets frequently yield different rural rate results and result in disparate treatment of similarly situated health care providers and cost-inefficiencies to the Universal Service Fund.

63. We adopt a median-based approach for rate determinations in lieu of rate averaging to account for the significant effect that a small number of outlier rates (i.e., those that are very high or very low in cost) can have on the average rural rate.<sup>177</sup> If a rural tier within a state has few service providers offering a certain service, there may be incentives to publicize artificially high rates to influence the rural rate. This incentive is stronger if the average rural rate is used rather than the median rate because the average rate can be more easily manipulated.<sup>178</sup>

64. The median figure established by our new approach represents a rate “ceiling,” in that the Commission will not provide support in excess of the median rate.<sup>179</sup> Health care providers may of

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<sup>176</sup> *RHC Program Open Data Platform*. The lowest of the three rural rates, \$294.24, was for T1 service requested by San Luis Valley Regional Medical Center from CenturyLink. The higher two rural rates - \$827.00 and \$2,077.65 - were for T1 services provided by TeleQuality and requested by Alamosa Dental Clinic (Valley-Wide Health Systems, Inc) and Convenient Care (Valley-Wide Health Systems, Inc).

<sup>177</sup> No commenters addressed a median-based approach to calculating rural rates. Some commenters support the concept of an average rural rate on the grounds that it will enhance transparency. *See, e.g.*, SpaceX Comments at 4. Others oppose it due to the lack of publicly available rate information that can result in misleading average figures. *See, e.g.*, SHLB Public Notice Comments at 3 (averaging rural rates “introduces a great amount of uncertainty and arbitrariness into the process because rates may vary based on technology and location [and] . . . may exclude rates that are actually available to customers in the marketplace”); TeleQuality Public Notice Comments at 2 (listing a number of “variables” that would lead to rural rate “second-guessing,” including “how would USAC or the Commission know if it had all the publicly available rates”).

<sup>178</sup> *See supra* paras. 55-58.

<sup>179</sup> GCI argues that instead of using total price for the service to determine the median for rates, the Commission should use the median based on per megabyte pricing. *See* GCI Second July 25, 2019 *Ex Parte* Letter at 10. We apply the median to the total price for the service because the Commission has defined rate for the purposes of computing Telecom Program support as “the entire cost or charge of a service, end-to-end, to the customer . . . .” *See Universal Service First Report and Order*, 12 FCC Rcd at 9128, paras. 674-75. In contrast, there is no legal support for assessing urban and rural rates based on per megabyte rates that are not charged to customers. *See* 47 U.S.C. § 254(h)(1) (requiring telecommunications carriers to provide telecommunications services at “rates charged for similar services in urban areas in that State”) (emphasis added). Indeed, pursuant to this Report and Order, health care providers will now be required to seek bids on specific end-to-end services. *See* Part III.D.1. The median urban and rural rates should be based on the total price of the service requested by the health care provider, not an alternative per megabyte pricing scheme as suggested by GCI. Further, determining median rates based on per megabyte rates (i.e., using rates for services with a much lower bandwidth to calculate the rural rate for the higher bandwidth services) would conflict with the requirement that the rates compared be functionally equivalent from the perspective of the end user—a standard for which advertised speed is a significant factor. *See* Part III.A.1; *See 2003 RHC Internet Access Order*, 18 FCC Rcd at 24564, para. 34. Further, we note that our use of a median to determine the ceiling for rural rates (rather than an average) mitigates any potential disparities between significantly higher or lower rates at the bounds of the 30% similar services range.



course enter into contracts with carriers at a rate lower than the median rural rate. If the health care provider enters into a contract with a carrier at a rate that falls below the median rural rate determined pursuant to our new rules, the health care provider should enter the *lower* of the two rates into the FCC Form 466 funding application that it submits to the Administrator.<sup>180</sup> We believe this approach balances the pro-competitive advantages of market-based rates with protections against possible rate manipulation in circumstances where insufficient levels of competition exist.<sup>181</sup>

65. Several commenters favor using only competitive bidding to set a fair market rate.<sup>182</sup> To these parties, reliance on market forces offers several benefits, including a check on outlier pricing that keeps prices low<sup>183</sup> and no need to depend on rates that they assert are often unavailable.<sup>184</sup> We do not agree with these commenters that there are sufficient competing service alternatives in all rural areas to allow for the exclusive reliance on market-based methods of rate determination.<sup>185</sup> Indeed, there is a striking lack of competition in the Telecom Program. In funding year 2017, of a total of 7,357 Telecom Program funding requests received by the Administrator, 6,699 requests included no bids, and 242 requests included only one bid, from carriers.<sup>186</sup> In other words, nearly 95% of requests for Telecom Program support were submitted without an effective competitive bidding process. Given these numbers, competitive bidding alone cannot be expected to set efficient rural rates. Nor would we expect carriers to compete on *rural* rates in their bids. After all, rural health care providers do not pay the rural rate—they

<sup>180</sup> See 47 CFR § 54.605(a), as adopted herein; Appx. A, Final Rules. Health care providers will be required to certify that the rural rate on their FCC Form 466 applications does not exceed the appropriate rural rate and service providers will be required to make the same certification on invoices submitted to the Administrator. See 47 CFR §§ 54.622(e)(1)(x), 54.627(c)(3)(F), as adopted herein; Appx. A, Final Rules.

<sup>181</sup> USTelecom argues that carriers should be permitted to request a rural rate higher than the median if the higher rural rate is derived from a competitively bid state master contract, is in a tariff or publicly available guidebook and has been charged to a retail customer purchasing the same or a similar service out of the tariff or guidebook without RHC Program or the E-Rate Program support, or is the same or lower than a rate the carrier is charging to a retail customer that is not supported by the RHC Program or the E-rate Program. USTelecom July 25, 2019 *Ex Parte* Letter at 1-2. We reject USTelecom's proposal. First, if the Administrator has determined that rates in state master contracts, tariffs, and guidebooks are for services that are the same or similar to the service requested by the health care provider, and those rates are available in the health care provider's rural tier, they should be included in the Administrator's median determination. The rates will, therefore, be considered in determining the appropriate rural rate ceiling for the pertinent service and rural tier. If a carrier believes that the resulting median would result in an objective, measurable economic injury, it may seek a waiver from the Commission by satisfying the criteria set forth in Part III.A.4.b. Second, USTelecom's third scenario essentially asks that we retain Method 1 of the current rural rate rule (i.e., determine rural rates using rates the carrier charges non-health care provider commercial customers for same or similar services), which for the reasons stated in this Report and Order, we decline to do. Finally, we conclude that USTelecom's proposal, which would require the Administrator to continue making rural rate determinations on a funding request-by-funding request basis, would be contrary to our expressed goals of making rural rate determinations transparent, predictable, and administratively simple. See Part III.A.5.

<sup>182</sup> See, e.g., GCI Public Notice Comments at 14; SHLB Public Notice Comments at 5; TeleQuality Comments at 13.

<sup>183</sup> See TeleQuality Comments at 13.

<sup>184</sup> See GCI Public Notice Comments at 9-10.

<sup>185</sup> There is support from commenters for the proposition that the Administrator set urban rate floors and rural rate ceilings. See, e.g., ACS Public Notice Comments at 5-6.

<sup>186</sup> *USAC Data Submission* at Appx. A, p. 3. In cases where no bid is received in response to a request for service or equipment on FCC Form 465, the rural health care provider has the option either to: (1) repost the FCC Form 465 for an additional 28 days to solicit bids; (2) use a current contract as a "standing bid" to obtain the requested service or equipment; or (3) select a service provider of its choosing. This last option requires that any services provided be compliant with what was originally stated on the bidding evaluation matrix and as requested on the FCC Form 465. USAC, *RHC Program: Competitive Bidding FAQ*, [https://www.usac.org/\\_res/documents/rhc/pdf/handouts/Competitive-Bidding-FAQ.pdf](https://www.usac.org/_res/documents/rhc/pdf/handouts/Competitive-Bidding-FAQ.pdf) (last visited May 31, 2019).

pay the urban rate. So while we cannot discount some possibility that competition could lower rural rates, the far greater likelihood is that carriers compete (in those discrete instances where they do compete) on urban rates and the non-price characteristics of the service.

66. What is more, even these commenters recognize that competitive bidding and rate limitations do not need to be mutually exclusive solutions. Commenters' proposals include, for example, establishing a uniform urban rate floor and rural rate ceiling within each state based on market prices,<sup>187</sup> pricing set by competitive bidding but with a change in the amount of the subsidy in the Telecom Program from the current 100% of the difference between the urban and rural rate to 95% of the difference,<sup>188</sup> and a "minimum contribution" approach wherein health care providers would be required to pay the greater of the urban rate or 1% of the rural rate.<sup>189</sup>

67. We believe that a uniformly applied standard for determining rural rates based on a state-wide pool of available rates significantly enhances the efficiency of the Telecom Program in several ways. First, a definitively determined rural rate will facilitate rate transparency, thereby reducing rural rate inconsistencies and simplifying the review process, thus expediting funding commitment determinations and encouraging more competition from service providers.<sup>190</sup> Second, by limiting rate determinations to available rates, rural rates are more predictable and easily verifiable, and harder for service providers to artificially inflate or otherwise manipulate. Third, the ability to determine a rural rate using available rates from other parts of the health care provider's state (under conditions where sufficient data is not available in the provider's rural area) eliminates the need for resource-intensive cost-based rural rate reviews by the Commission.<sup>191</sup>

#### **b. Allowing Cost-Based Rates Only Via Waiver**

68. Under our current rules, carriers may request approval of a cost-based rate from the Commission (for interstate services) or a state commission (for intrastate services) if there are no rates for same or similar services in that rural area or the carrier reasonably determines that the calculated rural rate is unfair.<sup>192</sup> The Commission adopted this cost-based mechanism when it created the Telecom Program in 1997,<sup>193</sup> but the cost-based rural rate mechanism was only invoked for the first time in funding year 2017, and since then, only a small number of carriers have attempted to use it.<sup>194</sup> Stated differently, the cost-

<sup>187</sup> See ACS Public Notice Reply Comments at 5-6.

<sup>188</sup> See SHLB Public Notice Comments at 6.

<sup>189</sup> See GCI Public Notice Comments at 32.

<sup>190</sup> GCI Public Notice Comments at 2 ("[C]ommenters broadly criticize the complexity of the current rules, as well as the inconsistency of their application – and the resulting uncertainty for Program participants.").

<sup>191</sup> See *infra* paras. 70-71 (discussing elimination of cost-based rural rates). Using rate data from other parts of the state also resolves the issue of the Administrator not knowing what to do when a state commission does not act on a request for approval of cost-based rates for intrastate service when, for example, the state commission does not have a mechanism to do so.

<sup>192</sup> 47 CFR § 54.607(b).

<sup>193</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 9121, para. 661.

<sup>194</sup> See, e.g., *Wireline Competition Bureau Seeks Comment on GCI Application for Review*, WC Docket No. 17-310, Public Notice, 34 FCC Rcd 396 (WCB 2019) (seeking public comment on GCI's request for review of decisions approving funding year 2017 cost-based rural rates); Letter from John T. Nakahata, Counsel to TeleQuality Communications, LLC, Harris, Wiltshire & Grannis LLP, to Marlene H. Dortch, Secretary, FCC at 1 (Feb. 5, 2019) (on file in WC Docket No. 17-310) (requesting approval of TeleQuality's funding year 2017 rural rates determined in part using the cost-based method); Letter from Karen Brinkmann, Counsel to Alaska Communications, Karen Brinkmann PLLC, to Marlene H. Dortch, Secretary, FCC at 2 (Mar. 13, 2019) (on file in WC Docket Nos. 02-60 and 17-310) (noting that Alaska Communications has submitted rates for approval based on cost for three consecutive funding years); Letter from Lance J.M. Steinhart, Esq., Attorney for Corcom Communications, Inc.,

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based rural rate mechanism is infrequently used and, thus, has not been an essential aspect of the Telecom Program for the vast majority of its history.

69. In the *2017 Promoting Telehealth Notice and Order*, we sought comments on eliminating the cost-based method of determining rates, which exists in the Commission's rules as, essentially, a safety valve for service providers that have no other means of determining a rural rate.<sup>195</sup> We sought comment on whether such a safety valve would be necessary under our proposed rules that would reduce the chance that health care and service providers could not find data to calculate a rural rate.<sup>196</sup> We subsequently sought additional focused comment on whether cost-based rural rates should be eliminated based on carriers' experience in preparing cost studies and submitting cost-based rural rates to the Commission for approval.<sup>197</sup>

70. We eliminate the cost-based support mechanism. To the extent the Commission created it in anticipation of rates for same or similar services not being available in some rural areas, such circumstances have not materialized on a significant scale, given how infrequently the cost-based mechanism has been invoked. Moreover, commenters generally disfavor the cost-based method for determining rural rates, which they view as challenging to calculate and difficult to obtain approval for due to the burdensome itemized cost summaries that the method requires.<sup>198</sup> Further, the rural rate methodology that we adopt in this Report and Order will include rates from a geographic range that is broader than a health care provider's immediate rural area, making it unlikely that the data necessary to determine a rural rate for a particular service will not be available.

71. We conclude that cost-based reviews should not be an alternative method of determining a rural rate under our rules but should be reserved for extreme cases where a carrier can demonstrate that determining Telecom Program support under the new rural rate rules adopted by this Report and Order would result in an objective, measurable economic injury. Parties that seek exemptions from the requirements of the Commission's rules for the other universal service support mechanisms do so through petitions for waiver.<sup>199</sup> To that end, we establish specific evidentiary requirements for carriers that seek waivers of our new rural rate rules in order to use a cost-based rate.

72. A petition seeking such a waiver will only be granted if, based on documentary evidence, the carrier demonstrates that application of the rural rate published by the Administrator would result in a

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Lance J.M. Steinhart, P.C., to Marlene H. Dortch, Secretary, FCC at 1 (Apr. 26, 2019) (on file in WC Docket No. 17-310) (requesting approval of Corcom Communication's cost-based rural rates); Letter from Sharon Thomas, Consultant to Midcontinent Communications, Inteserra Consulting Group, Inc., to Marlene H. Dortch, Secretary, FCC at 1 (Apr. 11, 2018) (on file in WC Docket No. 17-310) (requesting approval of Midcontinent Communication's cost-based rural rate).

<sup>195</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10653, para. 66.

<sup>196</sup> *Id.*

<sup>197</sup> *2018 Refresh Public Notice*, 33 FCC Rcd at 11708.

<sup>198</sup> See, e.g., ACS Comments at 27-28; GCI Comments at 32-36.

<sup>199</sup> Generally, the Commission may waive its rules for good cause shown. See 47 CFR § 1.3. The Commission may exercise its discretion to waive a rule where particular facts make strict compliance inconsistent with the public interest. See *Northeast Cellular Telephone Co. v. FCC*, 897 F.2d 1164, 1166 (D.C. Cir. 1990) (*Northeast Cellular*). In addition, the Commission may take into account considerations of hardship, equity, or more effective implementation of overall policy on an individual basis. See *WAIT Radio v. FCC*, 418 F.2d 1153, 1159 (D.C. Cir. 1969), cert. denied, 409 U.S. 1027 (1972); *Northeast Cellular*, 897 F.2d at 1166. Waiver of the Commission's rules is therefore only appropriate if special circumstances warrant a deviation from the general rule, and such deviation will serve the public interest. See *Connect America Fund, et al.*, WC Docket No. 10-90, Report and Order and Further Notice of Proposed Rulemaking, 26 FCC Rcd 17663, 17839-42, paras. 539-44 (2011) (*USF/ICC Transformation Order*).

projected rate of return on the net investment in the assets used to provide the rural health care service that is less than the Commission-prescribed rate of return for incumbent rate of return local exchange carriers (LECs).<sup>200</sup> This demonstration will constitute “good cause” to support a waiver of the rural rate rules.<sup>201</sup>

73. We emphasize that this standard of review constitutes a specific application of the “good cause” standard that generally applies to petitions for waiver of our program rules.<sup>202</sup> All such waiver requests must articulate the specific facts that demonstrate that the good cause waiver standard has been met, substantiated through documentary evidence as stated below, to demonstrate that granting the waiver would be in the public interest.<sup>203</sup> Further, a petition for such a waiver will not be entertained if it does not also set forth a rural rate that the carrier demonstrates will permit it to obtain no more than the current Commission prescribed rate of return authorized for incumbent rate-of-return LECs.<sup>204</sup> The Commission concludes that the current prescribed rate of return authorized for incumbent rate-of-return LECs is compensatory for carriers in the Telecom Program, and the Commission will not approve a rural rate that yields a higher return through the waiver process.<sup>205</sup>

<sup>200</sup> To meet its statutory obligation to ensure rates are just and reasonable, the Commission “must set the rate of return high enough to allow carriers to maintain their credit worthiness and attract capital, but no higher. If the rate [of return] is too high, customers pay unreasonably high prices both through direct payments to carriers and through excessive Universal Service Fund fees.” *Connect America Fund*, WC Docket No. 10-90, Wireline Competition Bureau Staff Report, 28 FCC Rcd 7123, 7124, para. 2 (WCB 2013). In 2016, the Commission determined that 9.75% will be the prescribed rate of return and implemented a timeframe to decrease the formerly prescribed rate of 11.25% to 9.75% by reducing the rate of return by 0.25% over six years. See *Connect America Fund*, WC Docket No. 10-90, Report and Order, Order and Order on Reconsideration, and Further Notice of Proposed Rulemaking, 31 FCC Rcd 3087, 3212, para. 326 (2016) (*2016 Connect America Fund Order*).

<sup>201</sup> See 47 CFR § 1.3. Here we lay out one specific application of our rules, we do not intend to change the general standard.

<sup>202</sup> *Id.*

<sup>203</sup> See *WAIT Radio*, 418 F.2d at 1157 n.9 (holding that the Commission “is not bound to process in depth what are only generalized pleas, a requirement that would condemn it to divert resources of time and personnel to hollow claims. The applicant for waiver must articulate a specific pleading, and adduce concrete support, preferably documentary”); *Rio Grande Family Radio Fellowship, Inc. v. FCC*, 406 F.2d 664, 666 (D.C. Cir. 1968) (“When an applicant seeks a waiver of a rule, it must plead with particularity the facts and circumstances which warrant such action.”). In addition to the evidentiary requirements below, if a request can demonstrate that a health care provider genuinely requires a low latency service, that could constitute special circumstances for granting a waiver.

<sup>204</sup> Effective July 2, 2019, the Commission’s authorized rate of return is 10.25%. On July 1, 2020, the authorized rate of return will be 10.0% and on July 1, 2021, the authorized rate of return will be 9.75%. See *Material to be Filed in Support of 2019 Annual Access Tariff Filings*, WC Docket No. 19-47, Order, DA 19-313, 2019 WL 1977344 at \*3, para. 7 (WCB May 1, 2019); *2016 Connect America Fund Order*, 31 FCC Rcd at 3212, para. 326.

<sup>205</sup> In its Second July 25, 2019 *Ex Parte Letter*, GCI asserts that the ILEC-prescribed rate of return is too low for the for interexchange services provided in Alaska and that the Commission-prescribed rate of return should be adjusted upwards to account for market risk due to the significant risk of non-payment and the lack of NECA pooling. See GCI Second July 25, 2019 *Ex Parte Letter* at 11. When determining the current Commission prescribed rate of return the Commission considered arguments that its prescribed rate of return should be adjusted upwards to account for market risk and rejected the request to upwardly adjust the prescribed rate of return to account for market risk because of lack of evidence that such an adjustment was required. See *2016 Connect America Fund Order*, 31 FCC Rcd at 3198-99, paras. 290-293. Similarly, although GCI asserts that interexchange carriers face additional market risk for providing services in Alaska and are entitled to higher rate of return, it has not presented any evidence to justify a higher rate of return is warranted for interexchange services and we decline to adopt one here. Therefore, the prescribed rate of return will continue to apply where a Commission-prescribed rate of return is applied to determine the revenue requirement calculation for federal universal support. See *2016 Connect America Fund Order*, 31 FCC Rcd at 3171, paras. 226 & 228 (explaining that the rate of return is a key input in the revenue

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74. *Evidentiary Requirements.* All petitions seeking such a waiver must include all financial data and other information to verify the service provider's assertions, including, at a minimum, the following information:

- Company-wide and rural health care service gross investment, accumulated depreciation, deferred state and federal income taxes, and net investment; capital costs by category expressed as annual figures (e.g., depreciation expense, state and federal income tax expense, return on net investment); operating expenses by category (e.g., maintenance expense, administrative and other overhead expenses, and tax expense other than income tax expense); the applicable state and federal income tax rates; fixed charges (e.g., interest expense); and any income tax adjustments;<sup>206</sup>
- An explanation and a set of detailed spreadsheets showing the direct assignment of costs to the rural health care service and how company-wide common costs are allocated among the company's services, including the rural health care service, and the result of these direct assignments and allocations as necessary to develop a rate for the rural health care service;<sup>207</sup>
- The company-wide and rural health care service costs for the most recent calendar year for which full-time actual, historical cost data are available;
- Projections of the company-wide and rural health care service costs for the funding year in question and an explanation of these projections;
- Actual monthly demand data for the rural health care service for the most recent three calendar years (if applicable);
- Projections of the monthly demand for the rural health care service for the funding year in question, and the data and details on the methodology used to make that projection;
- The annual revenue requirement (capital costs and operating expenses expressed as an annual number plus a return on net investment) and the rate for the funded service (annual revenue requirement divided by annual demand divided by 12 equals the monthly rate for the service), assuming one rate element for the service, based on the projected rural health care service costs and demands;
- Audited financial statements and notes to the financial statements, if available, and otherwise unaudited financial statements for the most recent three fiscal years, specifically, the cash flow statement, income statement, and balance sheets. Such statements shall include information regarding costs and revenues associated with, or used as a starting point to develop, the rural health care service rate; and
- Density characteristics of the rural area or other relevant geographical areas including square miles, road miles, mountains, bodies of water, lack of roads, remoteness, challenges and costs associated with transporting fuel, satellite and backhaul availability,

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requirement calculation that is used to determine universal service support and this "represcribed rate of return will apply in all situations where a Commission-prescribed rate of return is used").

<sup>206</sup> *Cf.*, e.g., 47 CFR § 61.38 (describing data and documentation, including a cost study and revenue impact, to support rate requests for carriers with gross revenues exceeding \$500,000); 47 CFR § 61.39 (describing data and documentation, including a cost study and revenue impact, to support rate requests for carriers serving 50,000 and fewer access lines); *see also* February 2019 Public Notice, 34 FCC Rcd at 537-38.

<sup>207</sup> *See* February 2019 Public Notice, 34 FCC Rcd at 537-38. *See generally* 47 CFR § 64.901 (explaining cost-allocation hierarchy principles).



extreme weather conditions, challenging topography, short construction season, or any other characteristics that contribute to the high cost of servicing the health care providers.

75. Failure to provide the listed information shall be grounds for dismissal without prejudice. The petitioner also shall respond and provide any additional information as requested by Commission staff. Such petitions will be placed on public notice for comment. The Wireline Competition Bureau is directed to approve or deny all or part of requests for waiver of the rural rate rules adopted herein.

## 5. Establishing an Urban and Rural Rate Database

76. A rural health care provider must provide an urban rate and rural rate on its funding request application to establish the discount on the supported service.<sup>208</sup> Under our current rules, that rate information may come from a variety of sources, some of which are unfamiliar or unavailable to health care providers. Lack of telecommunications expertise and access to data sets has led to health care providers relying heavily on consultants and service providers to obtain the urban and rural rate information required for their funding applications.<sup>209</sup> Securing that information can be time-consuming and administratively burdensome, and the information obtained is difficult for health care providers to verify.<sup>210</sup> The current process also opens the door to inconsistent rate determinations because each health care provider must secure and submit urban and rural rate information on a funding request-by-funding request basis.<sup>211</sup>

77. In the *2017 Promoting Telehealth Notice and Order*, we sought comment on ways to improve the collection and availability of urban and rural rate data.<sup>212</sup> We proposed standardizing the process by having carriers determine rates and providing that information to health care providers for their use when requesting funding.<sup>213</sup> We also asked whether the Administrator should be made responsible for collecting and making available rates instead of service providers since the Administrator would not have the potential financial incentive to manipulate rates that a service provider has.<sup>214</sup>

78. We direct the Administrator to create a publicly available database that lists the eligible services in the Telecom Program, the median urban rate and rural rate for each such service in each state, and the underlying rate data used by the Administrator to determine the median rates.<sup>215</sup> The urban and

<sup>208</sup> 47 CFR §§ 54.605-54.609.

<sup>209</sup> See AT&T Public Notice Comments at 1; NRHA Comments at 4.

<sup>210</sup> Although health care providers are required to submit documentation with their FCC Form 466 filings that substantiates the requested urban and rural rates, see 47 CFR § 54.609(a)(2); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 30 FCC Rcd 230 (WCB 2015), that documentation likely comes from the same source that provided the urban or rural rate data, and health care providers may not know whether other documents exist that would call those rates into question. We note, however, that service providers may be liable for any recoveries required because they supplied incorrect rate information. See *Implementation of the Debt Collection Improvement Act of 1996 and Adoption of Rules Governing Applications or Requests for Benefits by Delinquent Debtors*, MD Docket No. 02-339, Report and Order, 19 FCC Rcd 6540 (2004); see also *DataConnex NAL*, 33 FCC Rcd 1575; *Network Services Solutions, LLC, Scott Madison*, Notice of Apparent Liability for Forfeiture and Order, 31 FCC Rcd 12238 (2016) (*Network Services Solutions NAL*).

<sup>211</sup> See *supra* para. 58.

<sup>212</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10653, para. 68.

<sup>213</sup> *Id.*

<sup>214</sup> *Id.* at 10653-54, para. 69.

<sup>215</sup> See 47 CFR §§ 54.604(b), 54.605(b), as amended herein; Appx. A, Final Rules. We do not specify a specific format or platform for the database at this time. We recognize that, in developing the database, the Administrator may consider different options for program participants to access the urban and rural rate information in the database. We direct the Administrator to work with the Wireline Competition Bureau and the Office of the Managing Director to select the most beneficial method of making the database information publicly available.

rural rates shall be based on available rates (e.g., rates posted on service providers' websites, rate cards, publicly available contracts (i.e., state master contracts), undiscounted E-Rate Program data, tariffs (i.e., intrastate tariffs filed with state commissions, FCC's Electronic Tariff Filing System), and prior funding year Telecom Program rate data).<sup>216</sup> We direct the Administrator to determine the median urban and rural rate for eligible services as described in this Report and Order. We further direct the Administrator to establish the database and post its first set of median urban and rural rates on its website as soon as possible, but no later than July 1, 2020, and to update the rates periodically based on market and technology changes.<sup>217</sup> Rural health care providers generally will be required to use the currently posted median rates as their urban and rural rates when requesting funding on FCC Form 466 once the Administrator posts median urban and rural rates for the relevant services. In cases where a rural health care provider enters into a service agreement with a carrier featuring a rural rate lower than the rate posted by the Administrator, however, the health care provider should enter the lower rural rate.

79. The new urban and rural rate database to be established by the Administrator will provide several benefits. By centralizing and categorizing rate information in one place and by providing rural health care providers with pre-determined median urban and rural rates based on this information, the process will increase transparency compared to the current RHC Program. The database will allow quick identification of the median rates for a particular service within any state and how these rates were determined, ensuring that urban and rural rates are applied consistently and fairly to similarly situated health care providers seeking Telecom Program support for the same or similar services. In addition, because the database is publicly available, it will also promote predictability in the rate-setting process. As SpaceX points out, establishing an independent database "injects much needed transparency into the process."<sup>218</sup>

80. The new database approach should also lessen the risk of rate manipulation.<sup>219</sup> Our current rate rules have been difficult to enforce and may have invited fraud and rate manipulation.<sup>220</sup> Requiring rural health care providers to use the median rates as determined by the Administrator will prevent the health care provider and its carrier from using urban rates that are artificially low and rural rates that are artificially high, thereby safeguarding the integrity of the Telecom Program.

81. We also believe that having rates determined by the Administrator will greatly lessen the administrative burden that rural health care providers (and their carriers) currently experience.<sup>221</sup> Our new approach removes the onus of determining rates from Telecom Program participants and places this function in the hands of a single expert entity without a financial interest in the outcome. And while the Administrator will have to determine the median rates, it will not have to verify individually the rates on

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<sup>216</sup> To assist in the rate-determination process, service providers are encouraged to bring their available urban and rural rate data to the Administrator's attention.

<sup>217</sup> The first set of median urban and rural rate determinations must be published by July 1, 2020 so that carriers and health care providers have the information prior to commencing competitive bidding for funding year 2021. *See* Part III.E.1 (providing additional time for competitive bidding). A rate used in the Administrator's median determinations will be deemed effective for three years unless the Administrator determines that a new rate is available for the service.

<sup>218</sup> SpaceX Comments at 4-5; *see also* ACS Comments at 25 (a national database of all bids would allow rural health care providers to compare rates across rural areas).

<sup>219</sup> *See* TeleQuality Comments at 12.

<sup>220</sup> *See, e.g., DataConnex NAL*, 33 FCC Rcd 1575.

<sup>221</sup> *See* NCTA Comments at 7 (explaining that the Commission should not place the burden of determining the rural rate on service providers); NRHA Comments at 4 (allowing the Administrator to determine rates will relieve health care providers from having to perform the resource-intensive, duplicative task); ACS Reply Comments at 41-42 (standardizing the process of determining urban rates would provide administrative simplicity without sacrificing accuracy).

each funding request application other than to confirm that the rates match those on the website. This approach should ultimately result in a more efficient, transparent, and timely funding decision process.<sup>222</sup>

82. Commenters support requiring the Administrator to create a database for urban and rural rates.<sup>223</sup> NRHA, for example, states that “[h]ealth care providers are not well positioned, nor do they have the relevant expertise to determine [urban and rural] rates” and then argues that the Administrator is “best positioned” to determine the rate standards.<sup>224</sup> SpaceX concurs, explaining that “a database by the Administrator of rural and urban rate data, based on public sources, will eventually make it faster and easier for applicants to show that their proposed rates are representative of what would be charged for service in the area.”<sup>225</sup> Other commenters, however, question whether there is a sufficient number of available rates to make rate determinations by any party viable,<sup>226</sup> a concern that we do not share given the broad scope of rates that will be used to determine the median urban and rural rates made by the Administrator.

83. Two Commissioners dissent from these decisions, contending that the Commission should defer from implementing the rules for determining urban and rural rates in the Telecom Program because we do not “describe,” “analyze,” “test[],” “model[],” or “assess[]” the impact of those rules on the rural health care facilities that rely on the program today.<sup>227</sup> This contention is somewhat curious. *For one*, we do describe, analyze, and assess the impacts of the rules we adopt. For example, we find that the rules we adopt will provide more certain and transparent funding for rural health care providers across the board—more “predictable,” in the words of section 254 of the Act.<sup>228</sup> To the extent that our current rules subject rural health care providers to wildly varying urban rates for the same service (recall that

<sup>222</sup> We note that this streamlined and transparent process also reduces the potential for improper exercises of discretion by the Administrator, which, as discussed herein, currently reviews compliance with the Commission’s urban and rural rate rules on a funding request-by-funding request basis and without public scrutiny. Indeed, requiring the Administrator to publicly publish its median urban and rural rate determinations *and* the underlying data used in those determinations requires that the Administrator “show its work,” which will be much easier for the public and the Commission to review with only one median urban and rural rate determined for each eligible service in each rural tier within a state. *See* ACS July 19, 2019 *Ex Parte* Letter at 6 (“USAC should be required to ‘show its work’ in developing the urban and rural medians for purposes of the RHC telecom program.”).

<sup>223</sup> *See, e.g.*, SFC Comments at 5 (supporting suggestion that the Administrator create a database with all rate information submitted every year); ADTRAN Comments at 7 (advocating that the Administrator be responsible for setting the urban rates); TeleQuality Comments at 12 (stating that if USAC sets the urban rates, it will eliminate the potential for manipulation of the urban rates); ACS Comments at 28 (recommending that the Administrator develop the urban rate for each metropolitan area that would then be updated every two to three years to reflect any market changes; *see also* NCTA Comments at 7-8 (burden of determining urban and rural rate and rate differential should not fall to the service provider). *But see* YKHC Reply Comments at 10 (stating that the Commission should not micromanage rates); Utah Education Network Public Notice Comments at 1-2 (stating that the burden of determining the urban rate should fall to the service provider, with possible approval by the Commission or state commission).

<sup>224</sup> NRHA Comments at 4.

<sup>225</sup> SpaceX Comments at 4-5.

<sup>226</sup> *See, e.g.*, GCI Public Notice Comments at 11; SHLB Public Notice Comments at 5-6.

<sup>227</sup> Statement of Commissioner Rosenworcel (approving in part and dissenting in part); Statement of Commissioner Starks (approving in part and dissenting in part); *see also* Letter from Ron Wyden, United States Senator et al., to Ajit Pai, Chairman, Federal Communications Commission at 2 (July 30, 2019) (on file in WC Docket No. 17-310); Letter from Dan Sullivan, United States Senator, Lisa Murkowski, United States Senator, and Don Young, Member of Congress, to Ajit Pai, Chairman, Federal Communications Commission at 2 (July 31, 2019) (on file in WC Docket No. 17-310).

<sup>228</sup> 47 U.S.C. § 254(b)(5).

urban rates in Texas for voice grade business circuits ranged from \$9 to \$938<sup>229</sup>), the impact of using a statewide urban median will be to eliminate outliers and ensure that all rural health care providers pay what Congress mandated: “rates that are reasonably comparable to rates charged for similar services in urban areas in that State.”<sup>230</sup> And as discussed above, we conclude that existing rules have led to widely divergent rural rates, thus imposing wasteful inefficiencies on the program and its administration. In contrast, the rules we adopt today will eliminate divergent rural rates in similar areas, eliminating problematic incentives and the real costs this imposes on rural health care providers and the Universal Service Fund. Or to put it a different way (and as fully explained above), we have exercised our predictive judgment to develop an approach to developing both urban and rural rates that our analysis suggests is reasonable, that takes into account and balances the relevant considerations, and that fully satisfies the requirements of section 254 while safeguarding the Universal Service Fund from wasteful spending.

84. *For another*, these critiques ignore the real costs of delayed implementation. As described more fully above, current rules have enabled waste, fraud, and abuse in the Telecom Program and yielded results that appear contrary to Congress’s mandate. After all, how could rates of \$9 and \$938 for the same service be considered “reasonably comparable” to each other, let alone the urban rates in a single state? How could rural rates ranging from \$420 to \$4,308 for the same service in the same county (Tulare County, California)<sup>231</sup> be a faithful implementation of Congress’s command that the rural rate be based on “rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State”?<sup>232</sup> These discrepancies threaten the ability of the Telecom Program to fund the telecommunications services that health care providers need to deliver critical health care services to their rural communities from the Program’s limited resources. Program data establishes that commitments in the Telecom Program grew by more than 80% between funding year 2012 and funding year 2016.<sup>233</sup> And yet, as explained above, *more and more* of the program’s limited resources are devoted to *fewer* health care providers. The dissenting Commissioners do not offer any defense of existing rules and the negative impact they have on rural health care facilities—and delay would only prolong these problems. By removing the problematic provisions of our existing rules, our approach will enable rural health care providers to continue to receive the services and support they need, with fewer administrative burdens and at lower cost to the Universal Service Fund. Or in other words, it is neither necessary nor desirable to delay the benefits of implementing the new urban and rural rate rules.

85. *For yet another*, we find that no modeling is necessary at this point to reject the suggestion of one Commissioner, without factual basis, that health care providers in the most remote locations might be forced to close as a result of the new rules.<sup>234</sup> Ensuring that remote regions receive sufficient support is precisely why we divide rural areas into differing tiers (with an additional subtier for the most remote regions of our country). More fundamentally, health care providers will continue to receive needed telecommunications services “at rates that are reasonably comparable to rates charged for similar services in urban areas in that State,” as provided by Congress, and carriers are obligated to provide them service at that rate.<sup>235</sup> We also note that our waiver process helps ensure that any carrier

<sup>229</sup> *RHC Program Open Data Platform*.

<sup>230</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>231</sup> *RHC Program Open Data Platform*.

<sup>232</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>233</sup> *See supra* para. 42.

<sup>234</sup> Statement of Commissioner Rosenworcel at 1-2.

<sup>235</sup> 47 U.S.C. § 254(h)(1)(A); *see also* new section 47 CFR § 54.603(b) (*bona fide* requests by rural health care providers for telecommunications services shall be eligible for universal service support), as adopted herein; Appx, A, Final Rules.

outliers have an opportunity to receive sufficient support. Further, because of the prioritization rules we adopt today, the most rural and remote locations actually will have more protection than they do today, because those locations will receive prioritized funding.<sup>236</sup> What is more, health care providers will have a full year between the posting of the applicable urban rates and the first day they will begin to receive service at those rates, so they will have adequate time to adjust. Thus, participants in the Program will be protected from undue rate impacts under our new rules, and will receive support that is “specific, predictable and sufficient,” as required by Congress.<sup>237</sup>

86. In sum, we have adopted a process that eliminates largely subjective urban and rural rate determinations made by the applicants and service providers and substitutes objective determinations by the Administrator in full view of the public. We expect that the result will be a more equitable and efficient use of limited available funding and a more predictable application process for Program participants.

87. In its Second July 25, 2019 *Ex Parte* Letter, GCI contends that the Commission has engaged in unlawful delegation of functions to the Administrator. That is incorrect as both a legal and factual matter. Initially, GCI identifies no valid legal authority for its claim that the Commission is prohibited from delegating to the Administrator the administrative roles contemplated by this Report and Order. GCI argues, for example, that section 5(c)(1) of the Act blocks the Commission from assigning a role to the Administrator in administering the urban and rural rates for the program.<sup>238</sup> But nothing in that section mentions section 254. Rather, that section provides only that the Commission cannot delegate its ratemaking hearing authority under section 204(a)(2) of the Act, which does not apply to the development of urban and rural rates under section 254. Nor does section 5(c)(1) even mention section 205, the other provision upon which GCI relies.

88. In a contorted interpretation of the Act, GCI contends that section 205 of the Act applies to the Commission’s establishment of rural and urban rates under section 254(h)(1)(A). GCI then argues that because the section 204(a)(2) hearing function cannot be delegated (citing Section 5(c)(1)), the Administrator can have no role in establishing the applicable urban and rural rates for the Telecom Program.<sup>239</sup> But sections 205 and 204 simply do not apply to section 254(h)(1)(A), which is structured as a universal service obligation, and which uses very different statutory terms to describe the rate determinations involved.<sup>240</sup> Specifically, section 254(h)(1)(A) imposes a requirement on telecommunications carriers, as part of their universal service obligation, to provide service to eligible rural health care providers at rates “*reasonably comparable* to rates charged for *similar services* in urban areas in that State.”<sup>241</sup> It then entitles those carriers to “the difference, if any, between rates for services provided to health care providers for rural areas within a State and the rates for *similar services* provided

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<sup>236</sup> One of the dissents also objects to our adoption of revised prioritization rules and rules for health care consortia members without first analyzing the impact of those rules. Statement of Commissioner Starks at 1-2. But both of those rule changes are explicitly designed to prioritize funding to those health care providers most in need of support, so we do not understand what additional pre-adoption analysis of the impact of these rules on such providers would be helpful. Further, we do model how available funding would be allocated under the prioritization rules we adopt today based on the locations of health care providers currently participating in the Program and recent funding commitment data. See *infra* Fig. 6; Table 3.

<sup>237</sup> 47 U.S.C. § 254(b)(5).

<sup>238</sup> GCI Second July 25, 2019 *Ex Parte* Letter at 16-18.

<sup>239</sup> *Id.*, citing 47 U.S.C. § 155(c)(1).

<sup>240</sup> Even if the section 205(a) hearing requirement were deemed to apply here, section 204(a)(2) would not apply, because under section 254(h)(1)(A) there would be no carrier “filing” with the Commission of a “new or revised charge, classification, regulation, or practice. . . .” 47 U.S.C. § 204(a)(2).

<sup>241</sup> 47 U.S.C. § 254(h)(1)(A) (emphasis added).



to other customers in *comparable rural areas* in that State . . . .”<sup>242</sup> Had Congress intended for the Commission to conduct a section 204(a)(2) hearing in order to give effect to this universal service obligation, it would not have used such different language in section 254(h)(1)(A), and it would have presumably cross-referenced section 204.<sup>243</sup> Nor is the mere compilation of available rates and calculation of a median rate used to calculate universal service support amounts equivalent to a rate “prescription” under section 205(a) that would require a hearing, as GCI contends.<sup>244</sup> Indeed, although the Act and our rules discuss a rural “rate,” the Act and rules do not contemplate requiring or even allowing any carriers participating in the program to ever charge that rate (and hence it lies outside the scope of the ratemaking contemplated in sections 204 and 205 of the Act). Instead the “rural rate” is a legal placeholder simply used to carry out the statutory requirement of calculating “the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State.”<sup>245</sup>

89. In any event, the Commission has not delegated ratemaking authority to the Administrator. In this order, the Commission itself adopts rules dictating how urban and rural rates will be determined for the Telecom Program.<sup>246</sup> Those rules and this order contain specific requirements to which the Administrator must adhere in developing these rates. For example, the Commission has delineated the geographic areas that are to be considered “comparable” rural areas under section 254(h)(1)(A); it has determined which services are “similar” within the meaning of that statutory provision (including bandwidth tiers, service quality, etc.); and it has determined how the Administrator is to assemble the available rates that will form the basis for calculating the median urban and rural rates for relevant geographic areas. The Commission has also required the Administrator to make public not only the median rates but also all the rates that the Administrator used to calculate the median.

90. GCI nevertheless contends that the Commission has delegated “ultimate authority over RHC Program rates” to the Administrator.<sup>247</sup> But the only change we make in this order is to have the Administrator, rather than the service provider, make the initial determination of what the rural rate should be. We have not more delegated the “ultimate authority” over RHC Program rates to the Administrator than we delegated such “ultimate authority” to service providers under the prior rules. As always, the authority to establish the appropriate urban and rural rates under section 254(h)(1)(A) remains squarely with the Commission. First, the Commission ultimately decides what the rates should be and

<sup>242</sup> *Id.*

<sup>243</sup> *Compare, e.g.,* 47 U.S.C. § 254(a)(1), which references sections 410(c) (concerning the Joint Board) and 214(e) (concerning designation of eligible telecommunications carriers).

<sup>244</sup> GCI Second July 25, 2019, *Ex Parte* Letter at 16-18. Even if our adoption of a methodology for determining urban and rural rates were a rate “prescription,” as GCI contends, it would not require an individualized hearing. Instead, this rulemaking has provided interested parties with a “full opportunity for hearing” sufficient to satisfy section 205. *See AT&T v. FCC*, 572 F.2d 17, 21-22 (2d Cir. 1978).

<sup>245</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>246</sup> We also reject GCI’s contention that this order fails to justify what it claims are “ex ante rate-setting regulations” for BDS and other services when the Commission relies on market competition to ensure just and reasonable rates outside of the RHC Program. GCI Second July 25, 2019 *Ex Parte* Letter at 13-15. First, section 254(h)(1)(A) requires us to establish both the urban rate that the health care provider is entitled to pay and the rural rate, which determines the subsidy to which the telecommunications service provider is entitled. While we have some discretion in the methods by which we determine those rates, we are bound to set them nonetheless, and to adhere to the precise directions provided by the statute in doing so. This is a fundamentally different task than making decisions about the regulation of rates in the BDS and other contexts, where different statutory provisions apply and different policy considerations are relevant. Further, as we have discussed above, we cannot rely on market competition alone to determine the appropriate rural rate in the RHC Program, because rural health care providers pay only the “urban rate” and therefore do not have an incentive to seek a competitive rural rate.

<sup>247</sup> GCI Second July 25, 2019 *Ex Parte* Letter at 18.

how the rules should be applied and interpreted. Should a health care provider or service provider believe that the Administrator failed to follow the Commission's rules in determining the applicable urban or rural rates, or otherwise believe the Administrator erred, it may appeal that decision to the Commission, which will conduct *de novo* review.<sup>248</sup> Second, the Administrator is expressly prohibited from making policy or interpreting Commission rules. Section 54.702(c) of the Commission's rules, which applies to the RHC Program, prohibits the Administrator from making policy or interpreting the statute or Commission rules and requires the Administrator to seek guidance from the Commission when the Act or rules are unclear.<sup>249</sup>

91. For these reasons, there is no merit to GCI's alternative contention that the Commission has impermissibly delegated an "inherently governmental function."<sup>250</sup> If GCI were correct that the determination of initial rates under section 254(h)(1)(A) is an "inherently governmental function" that cannot be delegated, then the Commission could not have lawfully permitted service providers to calculate initial rural rates, as it did under the prior rules. Determining the initial urban and rural rates under section 254(h)(1)(A) is something the service providers and the Administrator have been doing for many years, always subject to the Commission's oversight and review, and it will be no different under the program rules we adopt today. Because the Administrator carries out this function only pursuant to the Commission's rules and guidance, and subject to its review, and because the Administrator is prohibited from making policy or interpreting rules or statutes, there is nothing "inherently governmental" in the Administrator's role—rather, the Commission continues to exercise that function.<sup>251</sup>

#### 6. Eliminating the Limitation of Support for Satellite Services

92. We eliminate, as no longer necessary, effective for funding year 2020, section 54.609(d) of the rules, which allows rural health care providers to receive discounts for satellite service, up to the amount providers would have received if they purchased functionally similar terrestrial-based alternatives, even where terrestrial-based services are available.<sup>252</sup> Under the Telecom Program, an applicant's support is based on the difference between rural rates charged for telecommunications services in the rural areas where the health care provider is located, and the urban rates charged for

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<sup>248</sup> See 47 CFR §§ 54.719, 54.723. The Commission's procedural rules make it clear that the Commission, not the Administrator, is the decisionmaker. The Commission's rules provide that parties must first seek review of Administrator decisions by the Administrator. 47 CFR § 54.719(a). If still aggrieved, a party may appeal to the Commission. 47 CFR § 54.719(b). The Wireline Competition Bureau may act on a request for review of an Administrator decision unless the request raises novel questions of fact, law or policy, in which case the Commission itself will act on those requests. 47 CFR § 54.722(a). Aggrieved parties also may appeal to the full Commission from a Bureau decision. 47 CFR § 54.722(a). Both the Bureau and the Commission conduct *de novo* review of the Administrator's decisions. 47 CFR § 54.723. The Commission, not the Administrator, acts upon waiver requests. 47 CFR § 54.719(c).

<sup>249</sup> Section 54.702(c) of the Commission's rules provides that "[t]he Administrator may not make policy, interpret unclear provisions of the statute or rules, or interpret the intent of Congress." It further provides that "[w]here the Act or the Commission's rules are unclear, or do not address a particular situation, the Administrator shall seek guidance from the Commission." 47 CFR § 54.702(c). The Administrator's determinations of median urban and rural rates pursuant to this Order is nothing like the exclusions from or additions to the rate base that the Commission deemed to be beyond the Bureau's delegated authority in *RAO 20*, 11 FCC Rcd 2957, 2957, 2961-62 at paras. 1, 3, 25-29 (1996), cited in GCI Second July 25, 2019 *Ex Parte* Letter at 21-22. In any event, those determinations are subject to Commission review on appeal from USAC decisions.

<sup>250</sup> GCI Second July 25, 2019 *Ex Parte* Letter at 18-20.

<sup>251</sup> This long-established regulatory scheme is thus a far cry from the delegation of authority to a board of coal producers and miners to establish maximum hours that was struck down in *Carter v. Carter Coal Co.*, 298 U.S. 238 (1936), cited by GCI. GCI Second July 25, 2019 *Ex Parte* Letter at 19 & n.86.

<sup>252</sup> 47 CFR § 54.609(d).

similar telecommunications services in the same state.<sup>253</sup> When the Commission established the RHC Program, in some areas throughout the United States and related territories, particularly remote and insular areas, satellite systems provided the only viable means for a rural health care provider to receive telecommunications services. Thus, a rural health care provider using satellite services typically did not receive a discount under the program because the cost of rural satellite service was compared to the cost of urban satellite service, and the price of satellite service typically did not vary between urban and rural areas, so rural health care providers generally did not receive discounts for satellite services under the Telecom Program.<sup>254</sup> In some cases, satellite-based services were more costly than traditional wireline services.<sup>255</sup> Thus, rural health care providers using satellite services were particularly disadvantaged under the Telecom Program. A single exception applied to rural health care providers located in areas with no terrestrial-based alternative, allowing rural health care providers to obtain some support for satellite services by permitting them to compare rural satellite rates to urban wireline rates to determine a discount in this limited context.<sup>256</sup>

93. In 2003, the Commission revised its rules to expand the exception by allowing rural health care providers to receive discounts for satellite services even when alternative terrestrial-based services are available. This allowed for discounts based on a comparison of rural satellite rates to urban wireline rates regardless of the availability of a functionally similar terrestrial-based alternative in the subject rural area.<sup>257</sup> The Commission believed imposing a cap on support for satellite service was necessary, however, because satellite services were often significantly more expensive than terrestrial-based services in rural areas.<sup>258</sup> Thus, where a rural health care provider opts for a more expensive satellite-based service when a cheaper terrestrial-based alternative is available, the health care provider is responsible for the additional cost.<sup>259</sup> The Commission found that this approach furthered the principle of competitive neutrality and recognized the role that satellite services may play in rural areas without unduly increasing the size of the Fund.<sup>260</sup>

94. In the *2017 Promoting Telehealth Notice and Order*, the Commission sought comment on whether the limitation on support for satellite services, when a terrestrial-based alternative is present, is still necessary if the proposed reforms to the rural rate calculation and to the competitive bidding process are adopted by the Commission.<sup>261</sup> The Commission sought comment on whether, if it retained the limitation, it should modify it based on ACS's suggestion to cap support at the lower of the satellite service rate or the terrestrial service rate where both services are available.<sup>262</sup> Further, the Commission sought comment on whether, if it were to modify this provision in the manner suggested by ACS, it should require all health care providers to provide rate information about both satellite and terrestrial

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<sup>253</sup> See 47 U.S.C. § 254(h)(1)(A).

<sup>254</sup> See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 17 FCC Rcd 7806, 7820, para. 38 (2002) (*2002 RHC Notice*); 47 CFR §§ 54.605, 54.607, 54.609 (2003).

<sup>255</sup> *2002 RHC Notice*, 17 FCC Rcd at 7820, para. 38.

<sup>256</sup> See *2003 RHC Internet Access Order*, 18 FCC Rcd at 24568, para. 42.

<sup>257</sup> *Id.* at 24568, paras. 43-44; 47 CFR § 54.609(d).

<sup>258</sup> *2003 RHC Internet Access Order*, 18 FCC Rcd at 24568, para. 44.

<sup>259</sup> *Id.*

<sup>260</sup> *Id.*

<sup>261</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10652, para. 65.

<sup>262</sup> *Id.* See, e.g., Letter from Richard Cameron, Counsel for ACS, to Marlene Dortch, Secretary, FCC, WC Docket No. 02-60, at 1-2 (filed Nov. 13, 2017); ACS Comments at 16-7, ACS Reply Comments at 22-26.

services, or whether there should be some criteria for determining when such a comparison is required.<sup>263</sup>

95. Commenters are divided over whether the Commission should retain the limitation on support for satellite services under section 54.609(d) of the rules or whether a modification to the limitation, as proposed by ACS, is a better way to cap support for satellite services. Specifically, SpaceX supports eliminating this limitation arguing that calculating the rural rate from available sources (including rates for satellite service) “will act as [a] mechanism to constrain the rural rate as applied to all providers” and continuing to apply section 54.609(d) will “incentivize rate gaming rather than the accurate reporting of rates by service providers in rural areas.”<sup>264</sup> USTelecom, on the other hand, supports ACS’s proposal to limit Telecom Program support to the lower of the rural rate for functionally similar satellite or terrestrial service, where both are available, claiming that providers are charging inflated rates for terrestrial service and by capping rates for terrestrial services based on the cost of functionally similar satellite alternatives, the Commission could eliminate tens of millions of dollars annually in wasteful spending under the Telecom Program.<sup>265</sup> GCI, however, disagrees with this position, arguing that ACS’s proposal fails to account for the importance of service quality and reliability for services purchased by health care providers, thus rendering the two services dissimilar for comparison purposes.<sup>266</sup>

96. We agree with SpaceX that the limitation on support for satellite services in section 54.609(d) of the rules is unnecessary where the rural rates are constrained to an average, or in the case of our newly adopted approach a median, of available rates (including satellite service to the extent functionally similar to the service requested by the health care provider) as determined by the Administrator.<sup>267</sup> The Commission previously adopted the cap on satellite service support because the prices of satellite services in rural areas were “often significantly more expensive than terrestrial-based services.”<sup>268</sup> As acknowledged by USTelecom, however, and reflected in the data reported by health care providers in the FCC Form 466, rates for satellite services are in many instances comparable to, and in some instances less expensive than, the cost of terrestrial-based services.<sup>269</sup> For example, in Alaska for funding year 2017, health care providers reported, on the FCC Form 466, rural rates ranging from \$30,000 to \$40,500 for a 10 Mbps satellite service per month.<sup>270</sup> In comparison, rural rates for a terrestrial-based 10 Mbps MPLS service in Alaska, in many instances, were between \$60,000 and \$75,000 per month.<sup>271</sup>

97. We believe the changes we make in this Report and Order in determining the rural rate place a check on the service provider’s ability to inflate the rural rate by requiring the rural rate to be determined by taking a median of available rates outside the health care provider’s immediate rural area (but within similarly tiered rural areas within the health care provider’s state).<sup>272</sup> This method of using the median takes into account rates by *all* competitive service providers offering services, including

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<sup>263</sup> 2017 *Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10652, para. 65.

<sup>264</sup> SpaceX Comments at 5-6.

<sup>265</sup> USTelecom Comments at 17.

<sup>266</sup> GCI Comments at 31.

<sup>267</sup> See SpaceX Comments at 5-6; see Part III.A.4a (discussing the newly adopted method for determining rural rates under the Telecom Program).

<sup>268</sup> 2003 *RHC Internet Access Order*, 18 FCC Rcd at 24568, para. 44.

<sup>269</sup> USTelecom Comments at 17; see *RHC Program Open Data Platform*.

<sup>270</sup> See *RHC Program Open Data Platform*.

<sup>271</sup> *Id.*

<sup>272</sup> See Part III.A.4 (discussing the newly adopted method for determining rural rates under the Telecom Program).

terrestrial and satellite services, but eliminates outlier rates that would unduly influence the rural rate determination. The median approach will thus alleviate concerns by USTelecom of excessively high terrestrial-based rates skewing the rural rate determination to the detriment of the Universal Service Fund. Treating both services equally when functionally similar also furthers the principle of technological neutrality and recognizes the role that *both* satellite and terrestrial services may play in delivering telehealth services in rural areas without placing significant demand on the Fund. Additionally, by strengthening our competitive bidding process and rules, we ensure that health care providers select the most cost-effective service offering based on their telehealth needs and do not purchase services that exceed their needs.<sup>273</sup> We therefore find that the need to cap support for satellite service at the lower of the satellite service rate or the terrestrial service rate, where both services are available, would serve no additional purpose. Accordingly, we reject ACS's proposal and eliminate section 54.609(d) of our rules.

## 7. Eliminating Distance-Based Support

98. We eliminate distance-based support, which allows rural health care providers to obtain support for charges based on distance.<sup>274</sup> With the reforms to the urban and rural rate calculations adopted in this Report and Order, specifically urban rates based on a state-wide median and rural rates based on a median within a rural tier, we find that distance-based support is no longer necessary.<sup>275</sup> Moreover, the Administrator-created and maintained databases and median rates will provide rural health care providers with a mandatory median urban rate and a median rural rate to guide their determination of the rural rate. We believe that the median rate determinations for urban and rural rates that we adopt in this Report and Order will provide a reliable proxy for reasonably comparable rates in a state. We expect the dataset that the Administrator will compile will include sufficient rate information to allow the Administrator to determine meaningful median urban and rural rates for use by rural health providers.<sup>276</sup>

99. Under current rules, support is based on either an urban/rural rate differential<sup>277</sup> or, if the offered service includes an explicit distance-based charge, distance-based charges.<sup>278</sup> The Commission adopted a distance-based rule in 1997 to ensure that rates charged to rural health care providers are reasonably comparable to urban rates.<sup>279</sup> At the time, the Commission considered that the main thrust of section 254(h)(1)(A) was to use universal support to reduce or eliminate disparities in telecommunication service rates based on distance.<sup>280</sup> The Commission reasoned that “[i]t is often distance-based charges, not differences between base rates for service elements, that create great disparities in the overall cost of telecommunications services between urban and rural areas,” emphasizing that distance-based charges are often a “serious impediment” to rural health care providers’ use of telemedicine.<sup>281</sup> Despite these predictions, very few health care providers use the distance-based approach for determining support

<sup>273</sup> See Part III.D.1 (requiring applicants to seek bids for particular services).

<sup>274</sup> 47 CFR § 54.609(a)(1).

<sup>275</sup> See Parts III.A.3-4.

<sup>276</sup> We note that commenters argue that the Business Data Services market is competitive, and services are priced the same regardless of geography and are not mileage based. See, e.g., AT&T Public Notice Comments at 4. We make note of this argument but do not adopt or reject it at this time.

<sup>277</sup> See 47 CFR §§ 54.605, 54.607.

<sup>278</sup> See 47 CFR § 54.609(a)(1).

<sup>279</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 9129, para. 675.

<sup>280</sup> *Id.* at 9127-28, paras. 673-744.

<sup>281</sup> *Id.* at 9128, para. 675.



amounts.<sup>282</sup> For funding year 2018, only 15 requests were filed seeking distance-based support, less than 1% of the total number of applications filed for the Telecom Program, and only nine of those requests were issued a funding commitment.<sup>283</sup>

100. Because of the limited use of the distance-based approach and the administrative benefits that would result if the Commission were to adopt a standardized support determination, the Commission sought comment on whether to eliminate the Telecom Program's distance-based support.<sup>284</sup> Based on the paucity of distance-based funding requests, the Commission surmised that distance-based support may no longer be necessary.<sup>285</sup> The Commission noted that eliminating the distance-based approach would likely reduce the administrative burden on the Administrator because it would no longer need to manage two separate rate methodologies for the Telecom Program. The Commission also pointed out that, in conjunction with the other proposals in the *2017 Promoting Telehealth Notice and Order*, eliminating the distance-based support would likely simplify the application process for rural health care and service providers.<sup>286</sup> The Commission also inquired whether in the absence of a distance-based approach, there should be some other method to determine rates for supported telecommunications services in those limited cases where "similar" urban and rural services cannot be found to generate a discount rate.<sup>287</sup>

101. While USTelecom does not specifically propose maintaining distance-based support, it recommends that the Commission establish a rebuttable presumption for the Telecom Program that non-mileage-based rates for telecommunications services outside Alaska are reasonably comparable between rural and urban areas.<sup>288</sup> USTelecom's proposal would, in effect, eliminate the base-rate support mechanism in the lower 48 states,<sup>289</sup> leaving distance-based support as the only method for calculating support under the Telecom Program.<sup>290</sup> We find that such a proposal fails to account for potential differences between urban and rural rates for many services offered by other providers and favors a hardly used method to determine support over one more universally used.<sup>291</sup> Further, current rules for calculating distance-based support are complex and require distance calculations (i.e., standard urban distance, maximum allowable distance) that may not be easily understood by rural health care providers.<sup>292</sup> By providing a mechanism to determine urban and rural rates that is less complex and more

<sup>282</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10656-57, para. 79 (fewer than 100 funding requests in funding year 2015 and funding year 2016 combined used this approach); *USAC Data Submission* at Appx. A, p. 3.

<sup>283</sup> *USAC Data Submission* at Appx. A, p. 3. In funding year 2017, just over 1% of the Telecom Program applications sought distance-based support. *Id.*

<sup>284</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10656-57, paras. 79-81.

<sup>285</sup> *Id.* at 10657, para. 80.

<sup>286</sup> *Id.*

<sup>287</sup> *Id.* at 10657, para. 81.

<sup>288</sup> USTelecom Comments at 12-15. Specifically, USTelecom contends that "the standard rate for many, if not most, non-mileage-based telecommunications services is the same in rural and urban areas." USTelecom Comments at 12.

<sup>289</sup> 47 CFR § 54.609(a)(2).

<sup>290</sup> 47 CFR § 54.609(a)(1).

<sup>291</sup> TeleQuality Reply Comments at 10 (indicating that there are significant differences between urban and rural rates for many services that TeleQuality and other providers offer to health care providers).

<sup>292</sup> Currently, the Telecom Program provides support for distance-based charges up to the maximum allowable distance equal to the distance of the requested service as calculated in the service's distance-based charge minus the standard urban distance. See 47 CFR §§ 54.605-609. The standard urban distance is the average of the longest diameters of all cities with a population of 50,000 people or more in a state. See 47 CFR §§ 54.605(c), 54.625(a). The maximum allowable distance is the distance from the health care provider to the farthest point on the

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straightforward, we believe we will simplify the application process for the rural health care provider so that it can focus on its primary business of providing health care. Finally, by eliminating the distance-based support method, we reduce the administrative burden on the Administrator by no longer requiring the Administrator to manage two separate rate methodologies in the Telecom Program. Although the distance-based approach was infrequently used by rural health care providers, the Administrator nonetheless was required to have in place the necessary procedures and processes to handle such requests.

## 8. Supported Services in the Telecom Program

102. Section 254(h)(1)(A) of the Act “explicitly limits supported services for [rural] health care providers to telecommunications services” for the Telecom Program.<sup>293</sup> Over time, as technology has evolved, the line between telecommunications services and other services is not always evident to some health care providers. We therefore take this opportunity to remind participants that the Telecom Program only supports telecommunications services and not private carriage services, network buildout expenses, equipment, or information services.<sup>294</sup> Services and expenses not covered by the Telecom Program may be supported to the extent eligible under the Healthcare Connect Fund Program.

103. The Communications Act, as amended by the Telecommunication Act of 1996, defines “telecommunications” as “the transmission, between or among points specified by the user, of information of the user’s choosing, without change in the form or content of the information sent and received.”<sup>295</sup> The Communications Act further defines “telecommunications service” to mean “the offering of telecommunications for a fee directly to the public, or to such classes of users as to be effectively available directly to the public, regardless of the facilities used.”<sup>296</sup> A “telecommunications carrier” is “any provider of telecommunications services” and such carrier “shall be treated as a common carrier.”<sup>297</sup> Thus, as summarized by the Commission, “[b]ecause telecommunications services meet the standard for common carriage, providers of telecommunications services—*i.e.*, telecommunications carriers—are acting as common carriers to the extent that they are providing such services.”<sup>298</sup> The Commission has previously found, when offered on a common carriage basis, that traditional voice service<sup>299</sup> and stand-alone Asynchronous Transfer Mode service, Frame Relay service, and other high-capacity business data services can be telecommunications services.<sup>300</sup>

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jurisdictional boundary of the city in that state with the largest population. See 47 CFR § 54.625(a). The health care provider must pay for any distance-based charges incurred for mileage greater than the maximum allowable distance. See 47 CFR § 54.625(c). The per-mile charge can be “no higher than the distance-based charges for a functionally similar service in any city in that state with a population of 50,000 over the standard urban distance.” See 47 CFR § 54.608(a)(1)(ii).

<sup>293</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 9107, para. 630.

<sup>294</sup> In issuing this reminder, we do not modify any service classification previously made by the Commission or issue any new telecommunications classifications. We specifically decline to modify the classifications of services eligible for Telecom Program support to include services that are not telecommunications services, as some commenters recommend. See ACS July 19, 2019 *Ex Parte* Letter at 3-6; Ninilchik July 22, 2019 *Ex Parte* Letter at 2; ANHB July 24, 2019 *Ex Parte* Letter at 2-3; Chugachmiut July 24, 2019 *Ex Parte* Letter at 1; Alaska Primary Care July 24, 2019 *Ex Parte* Letter at 2.

<sup>295</sup> 47 U.S.C. § 153(50).

<sup>296</sup> *Id.* § 153(53).

<sup>297</sup> *Id.* § 153(51).

<sup>298</sup> *2017 BDS Report and Order*, 32 FCC Rcd at 3568, para. 269.

<sup>299</sup> We note the Commission has never officially classified Voice over Internet Protocol as a telecommunications or information service. See *IP-Enabled Services*, WC Docket No. 04-36, First Report and Order and Notice of Proposed Rulemaking, 20 FCC Rcd 10245, 10259, para. 25 (2005). The Commission has, however, recognized that (continued....)

104. Services involving telecommunications provided on a private carriage basis are not common carriage services and therefore are not telecommunications services supported by the Telecom Program. The test of common versus private carriage focuses on: (1) whether the carrier holds itself out to serve indifferently all potential users; and (2) whether the carrier allows “customers to transmit intelligence of their own design and choosing.”<sup>301</sup> A carrier is not a common carrier where its “practice is to make individualized decisions, in particular cases, whether and on what terms to deal” and does not indiscriminately offer service to the public.<sup>302</sup> Private carriage lacks the quasi-public character that is a “critical” premise of common carrier classification.<sup>303</sup>

105. The Commission has also concluded that “infrastructure development is not a ‘telecommunications service’ within the scope of section 254(h)(1)(A)” and thus not supported by the Telecom Program.<sup>304</sup> The “acquisition of customer premises equipment such as computers and modems” along with “equipment needed by rural health care providers to establish telemedicine programs” are also not supported in the Telecom Program.<sup>305</sup> In addition, information services are not supported telecommunications services. The Communications Act defines an information service as “offering the capability for generating, acquiring, storing, transforming, processing, retrieving, utilizing, or making available information via telecommunications, and includes electronic publishing, but does not include any use of any such capability for the management, control, or operation of a telecommunications system

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carriers may offer VoIP on a common-carrier basis, in which case it would be a telecommunications service. *See id.* at 10267, para. 38; *see also USF/ICC Transformation Order*, 26 FCC Rcd at 18143, para. 1389.

<sup>300</sup> *2017 BDS Report and Order*, 32 FCC Rcd at 3463, para. 6 (“Business data services refers to the dedicated point-to-point transmission of data at certain guaranteed speeds and service levels using high-capacity connections.”); *Petition of AT&T Inc. for Forbearance Under 47 U.S.C. § 160(C) From Title II and Computer Inquiry Rules with Respect to its Broadband Services*, WC Docket No. 06-125, Memorandum Opinion and Order, 22 FCC Rcd 18705, 18711, para. 9 (2007) (stating that “carriers and end users traditionally have used these services for basic transmission purposes and that these services, unlike broadband Internet access services, are telecommunications services under the statutory definitions and thus subject to Title II”); *Appropriate Framework for Broadband Access to the Internet over Wireline Facilities et al.*, WC Docket No. 02-33 *et al.*, Report and Order and Further Notice of Proposed Rulemaking, 20 FCC Rcd 14853, 14860-61, para. 9 (2005) (stating that such special access services “do not inextricably intertwine transmission with information-processing capabilities” and thus are telecommunications services under the Communications Act).

<sup>301</sup> *See Southwestern Bell Telephone Co. v. FCC*, 19 F.3d at 1480; *National Association of Regulatory Utility Commissioners v. FCC*, 525 F.2d 630, 640-41 (D.C. Cir. 1976) (*NARUC I*); *National Association of Regulatory Utility Commissioners v. FCC*, 533 F.2d 601, 608-09 (D.C. Cir. 1976) (*NARUC II*); *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Declaratory Ruling, 14 FCC Rcd 3040, 3050, para. 21 (1999).

<sup>302</sup> *NARUC I*, 525 F.2d at 641; *see also 2017 BDS Report and Order*, 32 FCC Rcd at 3567, 3569, paras. 268, 272 (classifying offerings as private carriage where there was evidence of “highly-individualized decisions regarding any rates and terms they do offer for the relevant categories of services in order to meet the particular needs of a given customer.”).

<sup>303</sup> *2017 BDS Report and Order*, 32 FCC Rcd at 3568, para. 271 (“[T]he case-by-case decisions about whether to offer these services to a given customer described by Comcast and Charter stand in contrast to the ‘quasi-public character’ that is a ‘critical’ premise of common carrier classification . . . . The absence of this critical factor is central to our private carriage analysis of these services.”); *NARUC I*, 525 F.2d at 641.

<sup>304</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 9108-09, para. 634.

<sup>305</sup> *Id.* at 9105, para. 626; *Changes to the Board of Directors of the National Exchange Carrier Assoc., Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21, 96-45, Sixth Order on Reconsideration, Fifteenth Order on Reconsideration, 14 FCC Rcd 18756, 18781-82, at para. 40 (1999) (*Universal Service Fifteenth Order on Reconsideration*) (“There is nothing in section 254(h)(1)(A) that authorizes the provision of universal service support for the purchase of equipment by rural health care providers.”).

or the management of a telecommunications service.”<sup>306</sup> The Commission emphasized when creating the Telecom Program that “data links and associated services that meet the statutory definition of information services, because of their inclusion of protocol conversion and information storage, are not eligible for support under section 254(h)(1)(A).”<sup>307</sup> Non-supported information services would also include broadband Internet access services.<sup>308</sup>

106. The Healthcare Connect Fund Program, created pursuant to section 254(h)(2)(A) of the Act, authorizes the Commission to adopt rules to enhance access to advanced telecommunications and information services for health care providers “to the extent technically feasible and economically reasonable.”<sup>309</sup> The statutory scope of the services supported under the Healthcare Connect Fund Program is broader than just the telecommunications services supported under the Telecom Program. Accordingly, rural health care providers needing services not covered by the Telecom Program should seek support to the extent eligible under the Healthcare Connect Fund Program.<sup>310</sup>

**B. Prioritizing RHC Program Funding for Rural and Medically Underserved Areas**

107. We believe the steps taken in June 2018 to increase available funding,<sup>311</sup> combined with the program reforms we adopt in this Report and Order, will decrease the likelihood of demand exceeding the RHC Program cap in future years. Nevertheless, we conclude the goals of the RHC Program are better served by replacing the current proration rules with a prioritization system. The experience of the past three years has made clear that proration is a poor solution for the RHC Program. Health care providers have flooded the Commission with complaints about the uncertainty and financial hardship they face due to delayed funding decisions caused by proration.<sup>312</sup> Indeed, many health care providers have incurred costs for services without knowing until nearly the end of the funding year whether they would

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<sup>306</sup> 47 U.S.C. § 153(20).

<sup>307</sup> See *Universal Service First Report and Order*, 12 FCC Rcd at 9106-07, para. 630. However, the Commission did clarify that “the telecommunications component of access to an Internet service provider, provided by an eligible telecommunications carrier, is a telecommunications service eligible for universal service support . . . under section 254(h)(1)(A).” *Id.*

<sup>308</sup> Broadband Internet access service is “a mass-market retail service by wire or radio that provides the capability to transmit data to and receive data from all or substantially all Internet endpoints, including any capabilities that are incidental to and enable the operation of the communications service, but excluding dial-up Internet access service.” *Restoring Internet Freedom*, WC Docket No. 17-108, Declaratory Ruling, Report and Order, and Order, 33 FCC Rcd 311, 318-19, para. 21 (2018). We note the Commission has not formally addressed the regulatory classification of enterprise communications services such as Dedicated IP, Virtual Private Networks (VPNs), Wide Area Networks (WANs), and other network services that are implemented with various protocols such as Frame Relay/ATM, MPLS, and Provider Backbone Bridging (PBB) but has previously sought comment on this issue for purposes of determining Universal Service Fund contribution obligations. See *Universal Service Contribution Methodology*, WC Docket No. 06-122, Further Notice of Proposed Rulemaking, 27 FCC Rcd 5357, 5382, para. 44 (2012).

<sup>309</sup> See 47 U.S.C. § 254(h)(2)(A) (“The Commission shall establish competitively neutral rules – (A) to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit elementary and secondary school classrooms, health care providers, and libraries.”).

<sup>310</sup> 47 CFR § 54.634.

<sup>311</sup> See *2018 Report and Order*, 33 FCC Rcd at 6578, para. 9.

<sup>312</sup> See ACS Reply Comments at 6; Letter from Jeffrey Mitchell, Counsel for NETC and CTC, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 17-310, at 1 (filed Apr. 9, 2019); Letter from John Windhausen, Jr., Exec. Dir., SHLB, to Ajit Pai, Chairman, FCC, and Radha Sekar, CEO, USAC, WC Docket No. 17-310, at 1-4 (filed Mar. 15, 2019).

be funded, and, if so, to what extent.<sup>313</sup> Some health care providers are unwilling to assume the risk that the Administrator will not fund their requests, or not fully fund them, and have postponed projects that would bring critical health care services to their communities.<sup>314</sup> Some health care providers have even indicated to the Commission the administrative delays and financial toll of proration have made them reconsider participation in the RHC Program altogether.<sup>315</sup> Accordingly, we now change course and replace our proration rules with a new process that prioritizes funding based on the rurality of the site location and whether the area is considered medically underserved. This prioritization scheme will help expedite the processing of funding requests and provide added certainty for those health care providers in the most rural areas facing the greatest shortage of health care physicians.

108. Under the Commission's rules, proration is required when funding requests submitted during a filing window exceed the amount of available funds.<sup>316</sup> This process results in an across-the-board reduction of support by a pro-rata factor calculated by the Administrator.<sup>317</sup> All eligible support requests are reduced by the same percentage amount regardless of the location and need of the health care provider applicant.<sup>318</sup> Parties to the underlying contracts are responsible for any shortfall due to reduced support.<sup>319</sup> Either health care providers have to shoulder a larger portion of the cost of the supported services, or service providers will offer price reductions to avoid curtailing service, or some combination thereof.<sup>320</sup>

109. The RHC Program was a largely undersubscribed program until recent funding years. From its inception in 1997 to funding year 2015, RHC Program demand fell far short of the then-\$400 million program funding cap. Program commitments did not exceed \$100 million until funding year 2009 and did not exceed \$200 million until funding year 2014.<sup>321</sup> Accordingly, through funding year

<sup>313</sup> See Letter from John Kravitz, SVP/Chief Information Officer, Geisinger Health System, to Ajit Pai, Chairman, FCC, and Radha Sekar, CEO, USAC, WC Docket No. 17-310, at 2 (filed May 7, 2019); Letter from Matthew Schumacher, Dir. of Technology, Altru Regional Telehealth Network, to Ajit Pai, Chairman, FCC, *et al.*, at 2 (May 6, 2019) (on file in WC Docket No. 02-60); Letter from Jeffrey Mitchell, Counsel for NETC and CTC, to Marlene H. Dortch, Secretary, FCC, WC Docket 17-310, at 3 (filed Apr. 9, 2019); Letter from John Windhausen, Jr., Exec. Dir., SHLB, to Ajit Pai, Chairman, FCC, and Radha Sekar, CEO, USAC, WC Docket No. 17-310, at 1-4 (filed Mar. 15, 2019).

<sup>314</sup> See Letter from Jeffrey Mitchell, Counsel for SHLB *et al.*, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 17-310, at 2 (filed May 15, 2019).

<sup>315</sup> See Letter from John Windhausen, Jr., Exec. Dir., SHLB, to Ajit Pai, Chairman, FCC, and Radha Sekar, CEO, USAC, WC Docket No. 17-310, at 1 (filed Mar. 15, 2019).

<sup>316</sup> 47 CFR § 54.675(f).

<sup>317</sup> See *WCB Provides a Filing Window Period Schedule for Funding Requests under the Telecom Program and the Healthcare Connect Fund*, WC Docket No. 02-60, Public Notice, 31 FCC Rcd 9588, 9592 (WCB 2016) (discussing application of pro-rata process); USAC, *Funding Commitments, FY 2016 Funding Information*, <https://www.usac.org/rhc/tools/funding-commitments/archive/default.aspx> (explaining pro-rata factor calculation and application) (last visited May 16, 2019).

<sup>318</sup> 47 CFR § 54.675(f)(1)-(3).

<sup>319</sup> See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 32 FCC Rcd 5463, 5465, para. 10 (2017) (*2017 Alaska Waiver*).

<sup>320</sup> We note, however, that “service providers would need to seek waivers from the Commission to offer voluntary price reductions to health care providers.” See *2019 Order* at \*3, para. 11 & n.31; *2017 Alaska Waiver*, 32 FCC Rcd at 5466, para. 12.

<sup>321</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10636, Fig. 1. The large increase in funding in funding year 2009 reflects commitments made in connection with the 2006 RHC Pilot Program, established to provide funding to support state or regional broadband networks designed to bring the benefits of innovative

(continued....)



2015, the Administrator was able to process funding requests without any delays caused by assessing the need for proration and adjusting funding requests by a pro-rata factor. That changed in funding year 2016, when demand exceeded the funding cap by approximately \$20 million and the Administrator was required to calculate a pro-rata factor for the first time.<sup>322</sup> The Administrator was required to do so again when demand exceeded the overall funding cap in funding year 2017,<sup>323</sup> and in funding year 2018 when demand exceeded the separate \$150 million funding cap on multi-year commitment and upfront payment requests in the Healthcare Connect Fund Program.<sup>324</sup>

110. Although the Commission has either eliminated or mitigated the financial toll of proration on program participants in funding years 2016 through 2018,<sup>325</sup> it can do little about the time required for the Administrator to properly administer a proration scheme. Simply assessing the need for proration for a given funding year can cause lengthy delays in the processing of funding commitments and created uncertainty for service and health care providers. The Administrator cannot begin to assess the overall demand under a system based on filing windows until the filing deadline occurs. Even upon close of the filing window, the Administrator only has an estimate of demand for that funding year.

111. To confirm the need for proration, and avoid setting an excessively high pro-rata factor, the Administrator typically first reviews all requests for funding to determine the actual total demand for the funding year (e.g., screen request for anomalies, such as duplicate filings and obvious errors).<sup>326</sup> At present, this process is still a largely a manual one, and with more than 14,700 funding requests filed in recent funding years on average,<sup>327</sup> the process is time-intensive.<sup>328</sup>

112. Once determined that total demand exceeds available funding, the Administrator must then run calculations to determine the pro-rata factor,<sup>329</sup> and then adjust thousands of funding requests by that factor. Before issuing funding commitments, the Administrator must also review the funding requests for compliance with the Commission's rules. Altogether, these steps took the Administrator more than eight months to complete and issue commitments for funding years 2016 and 2017.<sup>330</sup> By

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telehealth and telemedicine to the neediest areas of the country. *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, para. 1 (2006) (*Pilot Program Order*).

<sup>322</sup> The Administrator applied a proration factor of 92.5% to eligible funding requests filed during the second filing window of funding year 2016 (i.e., funding for the eligible costs of the requested services was reduced by 7.5%). *See USAC, Rural Health Care Program, Funding Commitments, FY2016 Funding Information*, <https://www.usac.org/rhc/tools/funding-commitments/archive/default.aspx> (last visited June 6, 2018).

<sup>323</sup> *See 2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10667, para. 109.

<sup>324</sup> *See 2019 Order* at \*4, para. 12.

<sup>325</sup> In funding year 2017, the Commission waived its rules to allow for the carry forward of funds unused from prior funding years to reduce the effect of proration. *See 2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10667, para. 109. For funding year 2018, the Commission suspended the rule for multi-year funding commitments, treating such requests as single-year funding requests, which eliminated the need for proration. *See 2019 Order* at \*4, para. 12.

<sup>326</sup> 47 CFR § 54.675(f)(2).

<sup>327</sup> The total number of funding requests received for funding years 2016-2018 was 13,254, 16,081, and 14,846, respectively. *See USAC Data Submission* at Appx. A, p. 3.

<sup>328</sup> Even with an automated system, determinations are not instantaneous, and some manual review time is required to verify system conclusions.

<sup>329</sup> *See* 47 CFR § 54.675(f).

<sup>330</sup> *See FY2017 Funding and Proration Information Available Now*, RHC Newsletter (USAC), Apr. 5, 2018 (announcing funding year 2017 funding and proration information on March 16, 2018); USAC, *FY2016 Commitments to be Issued for Requests Filed During the Sep–Nov Filing Window Period* (Apr. 10, 2017), <https://www.usac.org/about/tools/news/news-archive.aspx>.

contrast, the Administrator began issuing funding requests for single-year funding year 2018 requests, which did not require a proration analysis, in half that time.<sup>331</sup> That said, commitments related to upfront payments and multi-year funding requests subject to the \$150 million Healthcare Connect Fund Program cap were delayed until almost the end of the second quarter in 2019 to address and avoid proration concerns.<sup>332</sup>

113. In the *2017 Promoting Telehealth Notice and Order*, the Commission sought comment on whether to replace the current proration system with some form of prioritization.<sup>333</sup> Comments were mixed on how to proceed with many generally favoring either: (1) prioritizing support based on rurality and/or areas with healthcare shortages;<sup>334</sup> (2) prioritizing one program over the other;<sup>335</sup> or (3) maintaining the current proration process.<sup>336</sup> Even those favoring proration in the short term note the current process creates hardship for health care providers and is not a long-term solution because proration fails to provide beneficiaries with specific and predictable support.<sup>337</sup> Some commenters question the Commission's long-established authority to limit and otherwise not fully-fund Telecom Program requests.<sup>338</sup>

114. The Commission adopted a proration mechanism for the RHC Program when there was little concern over whether demand would outpace available funds.<sup>339</sup> While the Commission has previously considered prioritization of RHC Program support in the event of a shortfall, it found proration preferable as a logical means of treating every applicant equally, regardless of the underlying circumstances.<sup>340</sup> We expect the reform measures adopted herein will help alleviate the strain on RHC

<sup>331</sup> See USAC, *RHC Program News for November 2018*, <https://www.usac.org/rhc/about/outreach/newsletters/2018/November.aspx> (last visited May 15, 2019). We recognize that even four months to issue a funding commitment is something to improve upon, and we direct the Administrator to take steps to that end. See Part III.E (discussing program administration improvements).

<sup>332</sup> See *2019 Order* at \*1, para. 1.

<sup>333</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10641-45, paras. 21-34.

<sup>334</sup> Many commenters stated that they supported a rurality-based approach if the Commission were to proceed with prioritization of RHC Program support. See ATA Comments at 3; APCA/NACHC Comments at 2; BBAHC Comments at 6; CATG Comments at 6; FHA Comments at 10-11; GCI Comments at 43; SHLB Comments at 15; TACHC Reply Comments at 1; YKHC Reply Comments at 6-7. Several commenters also supported prioritization based on medical shortage need if prioritization was required. See AHA Comments at 11-12; ANHB Comments at 7; National Council at 1; NHeLP/CRS Comments at 9-10.

<sup>335</sup> Comments were mixed on which RHC sub-program to prioritize over the other. Compare ACS Comments at 37; TeleQuality Reply Comments at 13 (favoring prioritization of the Telecom Program over the Healthcare Connect Fund Program) with KSLCC Reply Comments at 9-10; NETC Comments at 6; and WNY-RAREC Comments at 2 (favoring prioritization of the Healthcare Connect Fund Program over the Telecom Program).

<sup>336</sup> See AHA Comments at 11; AT&T Reply Comments at 17-18; CHC Comments at 1; CHRISTUS Comments at 4; SHLB Comments at 24; WNY-RAHEC Comments at 2.

<sup>337</sup> See AT&T Reply Comments at 17-18.

<sup>338</sup> See ACS Reply Comments at 45; ANHB Comments at 3; BRAAHC Comments at 4; CATG Comments at 3; GCI Comments at 42; SCF Comments at 3-4; TeleQuality Comments at 9.

<sup>339</sup> See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Fifth Order on Recon., 13 FCC Rcd 14915, 14940, paras. 39-40 (1998) (*1998 Proration Order*) (adopting proration); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 18 FCC Rcd 24546, 24575, para. 56 (2003) ("We do not think [prioritization] is necessary at this time because program demand has never approached the cap.").

<sup>340</sup> See *1998 Proration Order*, 13 FCC Rcd at 14940, paras. 39-40 ("We conclude, however, that the complexity of the [prioritization] proposals outweighs their utility. We conclude instead that we should adopt a pro-rata rule."); *2003 RHC Internet Access Order*, 18 FCC Rcd at 24575, para. 56 (2003) ("Based on our estimates and the comments we have received, we continue to believe that our current rules requiring pro-rata distribution of funds if (continued....)

Program funding caused by rising demand. However, if demand should outpace available funds in future funding years, the need for proration could result in not only added processing delays but also with applicants potentially experiencing detrimental reductions in support in a funding year, perhaps for several consecutive funding years. Proration could thus hamper the ability of all, equally, to obtain sufficient support for the telecommunications and information services, which are necessary to improve health care access in rural areas. This outcome is not what the Commission intended. We therefore disagree with those commenters urging us to retain the current proration process.<sup>341</sup> We now find prioritization preferable to proration because, among other things, prioritization will enable the Administrator to begin issuing funding decisions as soon as the application filing window closes and when sufficient funding exists.

115. Congress intended for section 254(h) to assist health care providers in rural areas with affordable access to modern communications services to enable them to provide medical and educational services to all parts of the nation.<sup>342</sup> To this end, the RHC Program helps to bridge gaps in local care access through telehealth services.<sup>343</sup> Accordingly, when considering where to prioritize limited funding to best serve the goals of the statute, we find relevant the rurality of the rural health care provider's location and the associated high cost barriers to providing telecommunications services and the level of medical care need in the subject area. This approach furthers the goals of section 254(h) and is consistent with the universal service principles of section 254(b). First, health care providers in more rural areas have less access to telecommunications and advanced services than those in less rural areas, and those services tend to be more costly.<sup>344</sup> Prioritizing limited funding for those areas fulfills the Commission's statutory mandate to preserve and advance universal service, including for "low-income consumers and

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requests exceed the cap, are the most effective and equitable means of distributing limited funds in accordance with the goals and purposes of the statute."); *Healthcare Connect Fund Order*, 27 FCC Rcd at 16822-23, para. 367 ("We do intend, however, to conduct further proceedings and issue an Order by the end of 2013 regarding the prioritization of support for all the RHC universal service programs. In the meantime, we will continue to rely upon, as a backstop, the approach codified in our existing rules, in the unlikely event that funding requests do reach the \$400 million cap before we have established other prioritization procedures.").

<sup>341</sup> See AT&T Reply Comments at 17-18 ("There is no consensus in the record to adopt some alternative prioritization. . . . [I]t is reasonable for the Commission to continue proration, on an interim basis until it implements the reforms. . . ."); AHA Comments at 11; CHC Comments at 1; CHRISTUS Comments at 4; WNY R-AHEC Comments at 2.

<sup>342</sup> See 47 U.S.C. § 254(h); Joint Explanatory Statement at 131 (explaining that Congress intended Section 254(h) "to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the Nation" and that "[t]he ability of . . . rural health care providers to obtain access to advanced telecommunications services is critical to ensuring that these services are available on a universal basis."); see also *Universal Service First Report and Order*, 12 FCC Rcd at 8795, para. 31 (stating the "level of discounts correlated to indicators of poverty and high cost [i.e., rurality] for schools and libraries . . . satisfies section 254(h)(1)(B)'s directive that the discount be an amount that is 'appropriate and necessary to ensure affordable access to and use of' the services eligible for the discount.").

<sup>343</sup> See, e.g., ACS Comments at 3 ("Through telehealth services supported by the program, Alaskan rural healthcare providers have developed the capability to provide emergency services, advanced diagnostics, specialized medical treatments, palliative care and mental health care at levels that previously were not possible."); AHA Comments at 4 ("Broadband-enabled telehealth solutions can help bridge the rural health care access gap, and, with the support of the RHC Program, the adoption of telehealth systems by health care providers has been on the rise."); TACHC Comments at 1 ("Without the RHCP, the cost of increasing data needs is prohibitive to expanding technology to solve provider shortages.").

<sup>344</sup> See, e.g., *Communications Marketplace Report*, GN Docket 18-231 *et al.*, Report, 33 FCC Rcd 12558, 12663, para. 193 (2018) ("The record indicates that a major barrier to additional competition throughout the United States is the high costs and low population densities common in rural parts of the country.").

those in rural, insular, and high cost areas.”<sup>345</sup> Second, in areas in which medical care is less available, there is a greater need for and reliance on delivery of health care services via telehealth (which in turn requires access to telecommunications and advanced services). Prioritizing funding for those rural areas with the greatest medical need thus also serves the public interest.<sup>346</sup>

116. When demand exceeds the funds available,<sup>347</sup> we will first prioritize support based on rurality tiers, with extremely rural areas getting the highest priority over less rural areas. We will further prioritize funding based on whether the area is a Medically Underserved Area/Population (MUA/P) as designated by the Health Resources and Services Administration (HRSA)).<sup>348</sup> We considered alternative prioritization criteria as proposed in the *2017 Promoting Telehealth Notice and Order*.<sup>349</sup> After weighing the various options, however, we conclude that prioritizing support based on the degree of rurality and the medically underserved nature of the population are the two criteria that best fulfill the statutory objectives governing the RHC Program.<sup>350</sup> The following chart shows the RHC Program prioritization categories and order of priority using these two factors followed by a map illustrating where these prioritization categories are located in the continental United States, Alaska, Hawaii, and Puerto Rico.

<b>Health Care Provider Site is Located in:</b>	<b>MUA/P</b>	<b>Not in MUA/P</b>
Extremely Rural Tier	<i>Priority 1</i>	<i>Priority 4</i>
Rural Tier	<i>Priority 2</i>	<i>Priority 5</i>
Less Rural Tier	<i>Priority 3</i>	<i>Priority 6</i>
Non-Rural Area <sup>351</sup>	<i>Priority 7</i>	<i>Priority 8</i>

<sup>345</sup> See 47 U.S.C. § 254(b).

<sup>346</sup> Because Congress intended section 254(h) to provide “affordable access” for rural health care providers, we find targeting limited funding based on need, in this case how rural the area is as well as the level of medical services available in the area, consistent the statute. We thus disagree with ACS that the statute does not permit considerations of rurality or medical need when considering the prioritization of funding. See ACS Comments at 36; ACS Reply Comments at 45.

<sup>347</sup> This would include not only the capped amount of funding but any unused carry-over funding from previous funding years that the Commission designates for use in funding commitments for a particular funding year.

<sup>348</sup> HRSA is an agency within the U.S. Department of Health and Human Services (DHHS) and is the “primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable.” HRSA, *About HRSA*, <https://www.hrsa.gov/about/index.html> (last visited July 9, 2019).

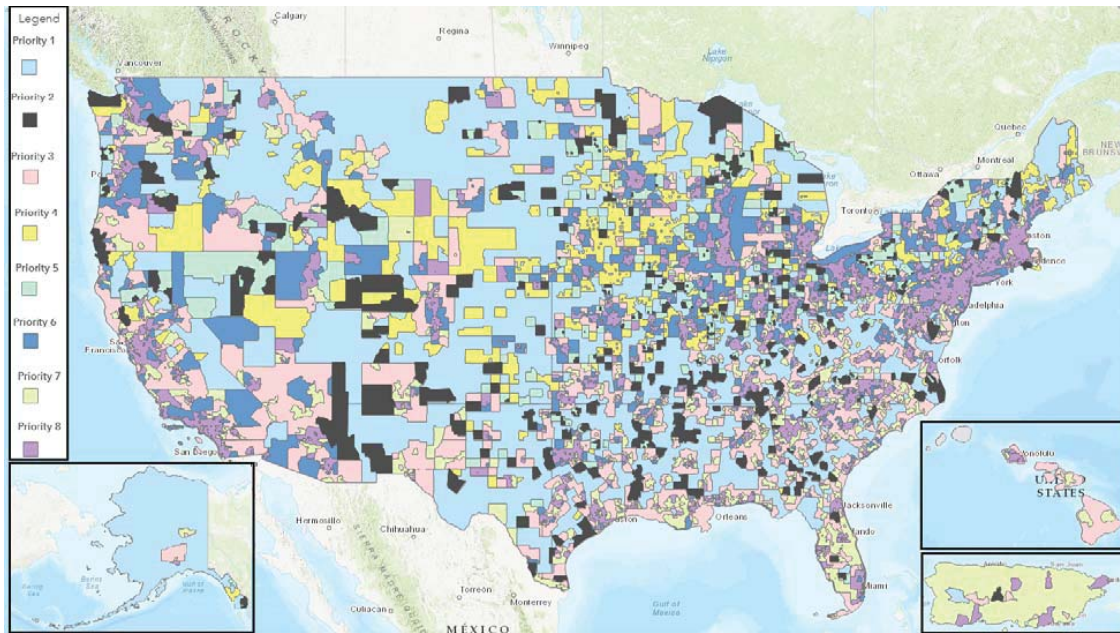
<sup>349</sup> The Commission sought comment on a number of prioritization approaches based on: (1) rurality or remoteness; (2) economic need or healthcare professional shortage; (3) program type (e.g., prioritizing one program over another); or (4) type of service (e.g., recurring cost versus one-time upfront cost for infrastructure). See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10641-45, paras. 21-34.

<sup>350</sup> Several commenters support a prioritization scheme based on rurality and/or health care shortage. See ANHB Comments at 7; ATA Comments at 3; BRAHC Comments at 6; BRAAHC Comments at 6; APCA/NACHC Comments at 2; CATG Comments at 6; CPC/FACHC Comments at 2; TACHC Comments at 1.

<sup>351</sup> Non-rural areas refer to areas not considered rural under the Commission’s current definition of “rural area” for purposes of program eligibility. 47 CFR § 54.600(b). We include non-rural areas on this prioritization chart in recognition that in the Healthcare Connect Fund Program, eligible health care providers located in urban areas may participate in the program as part of a consortium so long as the overall percentage of rural sites in the consortium are above a designated percentage threshold. See 47 CFR § 54.630(b). In this Report and Order, we separately address the appropriate percentage for consortium rural and non-rural sites going forward. See Part III.C.



**Fig. 6: Map Showing Prioritization Areas in the Continental U.S., Alaska, Hawaii, and Puerto Rico<sup>352</sup>**



### 1. Rural Prioritization Criteria

117. We first base rural prioritization criteria on the existing definition of rural area. Using the existing definition will simplify the process for participants and avoid an additional layer of complexity. The current definition lends itself well to prioritization because it includes gradations of rurality instead of having simply two categories, e.g., rural and non-rural.<sup>353</sup> Accordingly, using the current definition of “rural area” contained in section 54.600(b) of the Commission’s rules, 47 CFR § 54.600(b), we will prioritize funding based on the following rurality tiers:

- *Extremely rural* – counties entirely outside of a Core Based Statistical Area;<sup>354</sup>
- *Rural* – census tracts within a Core Based Statistical Area that does not have an urban area or urban cluster with a population equal to or greater than 25,000;

<sup>352</sup> Map created by applying the rurality tier criteria, as provided in the definition of “rural area” in section 54.600(b) of the Commission’s rules, against: (1) the 2010 Census data and corresponding designations for urban areas and clusters by the Census Bureau and Core Based Statistical Areas by the Office of Management and Budget; and (2) the MUA/P areas as designated by HRSA. See 47 CFR § 54.600(b); Census Bureau, *TIGER/Line Shapefiles*, <https://www.census.gov/cgi-bin/geo/shapefiles/index.php> (last visited July 23, 2019) (using year 2010 Census files for following layers: Census Tracts, Core Based Statistical Areas, Urban Areas, and Places); HRSA, *MUA Find*, <https://data.hrsa.gov/tools/shortage-area/mua-find> (last visited July 23, 2019).

<sup>353</sup> For this reason, we decline to use a separate definition for establishing rurality tiers as suggested by SHLB that would significantly broaden the number of locations considered Extremely Rural, Rural, and Less Rural for purposes of prioritization, thereby negating the value of using rurality criteria to better target funding to those areas considered rural under the Commission’s rules. See SHLB July 22, 2019 *Ex Parte* Letter at 2.

<sup>354</sup> Given that locations in the Extremely Rural tier will already receive the highest prioritization, we treat locations in the Frontier sub-tier in Alaska as Extremely Rural for the purposes of prioritization.



- *Less Rural* – census tracts within a Core Based Statistical Area with an urban area or urban cluster with a population equal to or greater than 25,000, but the census tract does not contain any part of an urban area or cluster with population equal to or greater than 25,000; and
- *Non-Rural* – all other non-rural areas.

118. We considered and decline to use, as a proxy for rurality, the “Highly Rural” areas used by the Department of Veterans Affairs for its Highly Rural Transportation Grant program.<sup>355</sup> Highly Rural areas are counties located in 25 states, primarily in the west and southwest United States, with a population density of fewer than seven people per square mile.<sup>356</sup> Several commenters supported the use of Highly Rural areas.<sup>357</sup> We find Highly Rural areas lack the necessary gradations of rurality and create an additional layer of complexity as to what is considered rural for purposes of prioritization.<sup>358</sup> For example, using just a Highly Rural designation would prioritize only one category of rural areas for funding and would not allow the Commission to set subsequent prioritization levels among other areas that likely have varying degrees of rurality. In comparison, the current definition of rural area allows the Commission to designate multiple prioritization levels based on rurality. Moreover, creating a definition of rural just for prioritization that is separate and apart from the definition used for funding eligibility would further complicate the process for applicants and increase the burden for administering the program. With the rejection of using Highly Rural areas, we likewise reject GCI’s alternative proposal to prioritize funding for such areas in exchange for increased minimum payments by health care providers over a five-year period.<sup>359</sup>

119. Additionally, we decline to base rurality on the number of patients in rural areas served as suggested by some commenters rather than the location of the health care provider.<sup>360</sup> Such an approach would not only increase the complexity of determining prioritization but would also potentially shift funding to health care facilities in urban areas. For example, the Commission would need to determine, and then update, the areas where patients served by each participating health care facility actually live to determine the facilities entitled to funding prioritization. Commenters supporting this approach fail to

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<sup>355</sup> This program provides free transportation to VA or VA-authorized health care facilities. Thus far, the Department of Veteran Affairs has only awarded grants to facilities serving Highly Rural areas in 11 states. VA, *Highly Rural Transportation Grants* (May 17, 2019), [https://www.va.gov/healthbenefits/vtp/highly\\_rural\\_transportation\\_grants.asp](https://www.va.gov/healthbenefits/vtp/highly_rural_transportation_grants.asp).

<sup>356</sup> See VA, *Listing of Highly Rural Counties* (May 17, 2019), [https://www.va.gov/healthbenefits/vtp/publications/HR\\_counties.xlsx](https://www.va.gov/healthbenefits/vtp/publications/HR_counties.xlsx).

<sup>357</sup> See ANHB Comments at 7; BBAHC Comments at 7; CATG Comments at 6; GCI Comments at 43.

<sup>358</sup> We note, particularly in Alaska, our Extremely Rural tier largely encompasses the areas designated as Highly Rural by the Department of Veterans Affairs. So those commenters representing interests in Alaska, urging use of Highly Rural areas, are likely to still receive a high priority in funding based on the rurality levels adopted. GCI, the proponent of a prioritization alternative based on Highly Rural areas, also agreed that an approach prioritizing extremely rural areas using current the Commission’s current definition of rural area was workable. GCI Comments at 47-48.

<sup>359</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10643, para. 29; Letter from John T. Nakahata, Counsel to General Communication, Inc., to Marlene H. Dortch, Secretary, FCC at 1-2 (Nov. 2, 2017) (on file in WC Docket No. 02-60). Minimum payments would start at 1% of the rural rate and increase annually until reaching 5% of the rural rate at year five. *Id.* We find this proposal goes beyond mere prioritization and touches on financial discipline for Telecommunications Program participants. We decide this issue is more appropriately addressed in the context of reforming urban and rural rate calculations for the Telecom Program, which is addressed separately in this Report and Order.

<sup>360</sup> See ATA Comments at 3; FHA Comments at 10-11; HIMSS Comments at 4.

suggest how such a process is administratively feasible.<sup>361</sup> In addition, we recognize many rural Americans have limited local opportunities for health care access and must travel to more populated areas for quality care. Accordingly, urban health care facility sites, participating as part of a consortium under the Healthcare Connect Fund Program, and that serve patients living in rural areas could receive funding priority based on this approach. One of the major goals of the RHC Program is to help promote local access in rural areas for health care so patients do not have to travel as far to obtain care. Prioritizing based on how many rural patients a facility serves could act contrary to this goal by shifting the funding priority to more populated areas that likely already have greater quality health care delivery systems than more rural areas.

## 2. Health Care Shortage Measure

120. Several commenters supported prioritization based on economic need or healthcare professional shortages to the extent the Commission required a second prioritization criteria.<sup>362</sup> The most commonly used Federal shortage designations are the Medically Underserved Areas and Populations (MUA/P) and the Health Professional Shortage Area (HPSA) designations.<sup>363</sup> Both are administered by the Health Resources & Services Administration (HRSA), but are based in different statutory provisions for different Federal programs.<sup>364</sup> The designation criteria for both rely on measures of physician supply relative to the size of the local population to assess geographically available care.<sup>365</sup> MUA/Ps, however, also include weighted need-based variables for low-income, infant mortality, and population age.<sup>366</sup> Designations are used to identify counties and census tracts not adequately served by available health care resources, and in the case of HPSAs, individual facilities that provide care to HPSA-designated areas or population groups.<sup>367</sup> Both methods primarily rely on state governments, i.e., the state primary care office, to identify areas or populations for designation and to gather information to document satisfaction of the designation criteria.<sup>368</sup> Designations are approved by HRSA. Once designated, MUA/Ps are not subject to any subsequent renewal or update requirement. The U.S. Department of Health & Human Services is required to conduct periodic reviews and revisions for HPSA designations.<sup>369</sup>

121. To determine whether an area is medically underserved, we will use, with limited exception, the MUA/P as designated by HRSA.<sup>370</sup> MUA/P designation relies on the Index of Medical

<sup>361</sup> See ATA Comments at 3; FHA Comments at 10-11; HIMSS Comments at 4.

<sup>362</sup> See AAFP Comments at 2; AHA Comments at 12; ANHB Comments at 7; APCA/NACHC Comments at 2; CATG Comments at 6; NCBH Comments at 1; NOSORH Comments at 3; TACHC Reply Comments at 1.

<sup>363</sup> See Eileen Salinsky, Health Care Shortage Designations: HPSA, MUA, and TBD, Background Paper No. 75, National Health Policy Forum (2010), [https://hsrsc.himmelfarb.gwu.edu/sphhs\\_centers\\_nhpf/225/](https://hsrsc.himmelfarb.gwu.edu/sphhs_centers_nhpf/225/).

<sup>364</sup> *Id.*

<sup>365</sup> See HRSA, *Health Professional Shortage Areas (HPSAs)*, <https://bhwh.hrsa.gov/shortage-designation/hpsas> (last visited July 1, 2019); HRSA, *Medically Underserved Areas and Populations (MUA/Ps)*, <https://bhwh.hrsa.gov/shortage-designation/muap> (last visited July 1, 2019).

<sup>366</sup> *Id.*

<sup>367</sup> See HRSA, *Types of Designations*, <https://bhwh.hrsa.gov/shortage-designation/types> (last visited July 8, 2019).

<sup>368</sup> See HRSA, *Shortage Designation Application and Scoring Process*, <https://bhwh.hrsa.gov/shortage-designation/application-scoring-process> (last visited May 24, 2019).

<sup>369</sup> See 42 U.S.C. § 254e(d).

<sup>370</sup> See 2017 Promoting Telehealth Notice and Order, 32 FCC Rcd at 10645, para. 34 (proposing use of MUA/Ps); HRSA, *MUA Find*, <https://data.hrsa.gov/tools/shortage-area/mua-find> (last visited July 2, 2019). We will include MUA/Ps recommended by a state governor as an exceptional MUP. HRSA, *Medically Underserved Area/Population (MUA/P) Application Process*, <https://bhwh.hrsa.gov/shortage-designation/muap-process> (last visited July 2, 2019). While these areas do not technically meet the criteria used for determining MUA/Ps, they (continued....)

Underservice (IMU), developed by the U.S. Department of Health & Human Services, which is calculated on a 1-100 scale (with 0 representing completely underserved and 100 representing best served or least underserved). An area or population with an IMU of 62.0 or below qualifies for designation as an MUA/P. The IMU is calculated by assigning a weighted value to an area or population's performance on four demographic and health indicators: (1) provider per 1,000 population ratio; (2) percent population at 100% of the Federal Poverty Level; (3) percent of population age 65 and over; and (4) infant mortality rate.<sup>371</sup> As of June 10, 2019, MUA/P designated areas covered 41.6% of the 2010 U.S. population.<sup>372</sup> We recognize rural areas may experience shortages in other health care areas, e.g., mental health services and other specialty areas, but adding additional shortage designation types would significantly increase the complexity of the prioritization process.<sup>373</sup> Accordingly, we decide to measure shortages based on primary care at this time to facilitate predictability and to simplify the prioritization process.

122. We find MUA/Ps have two distinct advantages over HPSAs for purposes of RHC Program prioritization. First and most importantly, the MUA/P designation criteria includes variables for poverty, infant mortality, and population age in addition to provider supply as compared to population. Use of the MUA/P ensures consideration of population indicators for health need in addition to the number of primary care physicians in the area. Second, the focus on primary care with counties, census tracts, block groups, and blocks designated as shortage areas makes administering MUA/Ps in the prioritization process relatively straight-forward as compared to HPSAs. We note that by using MUA/Ps, we will, however, lose some degree of accuracy as compared to HPSAs because there is no requirement for renewal or subsequent review of MUA/P designations. But we find the other benefits of using MUA/Ps outweigh this concern at this time. That said, we will monitor and plan to revisit the use of MUA/Ps in the future to determine whether this proxy is sufficient for identifying medically underserved areas.

123. We disagree with those few commenters opposing prioritization based on medical need, arguing such an approach is unworkable.<sup>374</sup> According to these commenters, identifying medically underserved areas is difficult, too subjective, impossible to implement, and subject to false positives.<sup>375</sup> We find these statements conclusory without any supporting evidence. These statements also ignore the availability of objectively designated medically underserved areas by a Federal agency, which we can incorporate into a prioritization system.

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have satisfied the alternative showing required for recommendation for exceptional designation and have been approved by HRSA for such designation. *Id.*

<sup>371</sup> See Health Services Amendments Act of 1986, Pub. L. No. 99-280, enacted in 1986; Dept. of Health, Education, and Welfare, Office of the Secretary, Health Maintenance Organizations, Designation of Medically Underserved Areas and Population Groups, 40 Fed. Reg. 40315 (Sept. 2, 1975). Poverty level is based on poverty guidelines issued by the U.S. Department of Health & Human Services annually. These guidelines are a simplified version of the poverty thresholds updated each year by the Bureau of the Census.

<sup>372</sup> Compare HRSA, *MUA Find*, <https://data.hrsa.gov/tools/shortage-area/mua-find> (last visited July 8, 2019) *with* Census Bureau, *Decennial Census Datasets*, <https://www.census.gov/programs-surveys/decennial-census/data/datasets.2010.html> (last visited July 8, 2019).

<sup>373</sup> For example, telepsychiatric services are the only psychiatric services available in Seward, Alaska. GCI NPRM Comments at 11-12.

<sup>374</sup> See GCI Comments at 49-50; KSLLC Comments at 8; WNY R-AHEC Comments at 3.

<sup>375</sup> See GCI Comments at 49-50; KSLLC Comments at 8; WNY R-AHEC Comments at 3.

### 3. Application of Prioritization Factors

124. We direct the Administrator to fully fund all eligible requests falling in the first prioritization category before funding requests in the next lower prioritization category.<sup>376</sup> The Administrator will continue to process all funding requests by prioritization category until there are no available funds. If there is insufficient funding to fully fund all requests in a particular prioritization category, then the Administrator will prorate the funding available among all eligible requests in that prioritization category only pursuant to the current proration process. That is, the Administrator would divide the total remaining funds available by the total amount of demand within the specific prioritization category to produce a pro rata factor. The Administrator would then multiply the pro rata factor by the total dollar amount requested by each applicant in the prioritization category and then commit funds consistent with this calculation. While we are changing the overall prioritization process to minimize proration, we find limited use of proration prudent to equitably address instances where funding is insufficient for all applicants similarly situated within the same prioritization category. The Administrator will then deny requests falling within subsequent prioritization categories due to lack of available funds.

125. This prioritization process applies equally when demand exceeds the \$150 million Healthcare Connect Fund Program cap for upfront and multi-year commitments. We clarify that if requests for support exceed both the overall RHC Program cap and the \$150 million Healthcare Connect Fund Program cap, the Administrator would first apply the prioritization process adopted herein to requests subject to the \$150 million Healthcare Connect Fund Program cap as that may eliminate the need to prioritize funding for the RHC Program cap. For example, if requests for support total \$650 million, which includes \$250 million in requests subject to the \$150 million cap, then first applying the prioritization process to the upfront and multi-year requests would bring total demand to \$550 million and within the overall RHC Program cap.

126. We recognize funding requests submitted by a consortium may contain multiple member sites falling in more than one prioritization categories, including member sites in non-rural areas. Nonetheless, the same prioritization process will apply, meaning those consortium sites in the highest prioritization category would receive funding commitments while other consortium sites in less rural and non-rural areas may not, i.e., based on prioritization, the consortium may only get a partial grant for some but not all of its sites. This potential outcome could dissuade future consortium participation but is necessary to better ensure support is directed to the most rural and medically underserved areas when demand exceeds the available support in a funding year. This outcome will also eliminate additional complexity in trying to prioritize consortia requests based on the percentage of member sites falling into particular prioritization categories as suggested in the *2017 Promoting Telehealth Notice and Order*.<sup>377</sup>

127. Under the approach we adopt, prioritization will not depend on whether the applicant seeks support under the Telecom or Healthcare Connect Fund Programs.<sup>378</sup> We seek to both ensure Telecom Program applicants have telecommunications services necessary to provide health care services and also support the deployment and adoption of advanced, next-generation broadband capabilities as promoted by the Healthcare Connect Fund Program.<sup>379</sup> Accordingly, at this time, we decline to prioritize

<sup>376</sup> We did consider using varying percentage amounts of reduced support as is done in the E-Rate Program but find fully funding requests is more straight-forward and targeted to address the neediest areas.

<sup>377</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10642-43, para. 28.

<sup>378</sup> Some commenters supported prioritization based on program type but were mixed on which program the Commission should prioritize over the other. See ACS Comments at 37; KSLLC Comments at 7; NHeLP Comments at 9-10; NOSORH Comments at 3; SHLB Comments at 25; TeleQuality Comments at 9; WNY R-AHEC Comments at 2.

<sup>379</sup> We note that while each program is focused on different types of services there is some overlap. For example, both the Telecom and Healthcare Connect Fund Programs support telecommunications services, albeit the  
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funding based on program type and will treat both programs equally.<sup>380</sup> We also disagree with those commenters who state the language of section 254(h) requires the Commission to favor the Telecom Program over the Healthcare Connect Fund Program.<sup>381</sup> The language of section 254(h) does not expressly require such prioritization; Congress did not express such an intent in the Joint Explanatory Statement accompanying the enactment of section 254(h); and the Commission has never interpreted the statute in this manner. Further, section 254(h)(1)(A) does not by its terms or otherwise require the Commission to prioritize support under that section over support to health care providers under section 254(h)(2)(A) or to other universal service programs under section 254.<sup>382</sup> For the reasons discussed herein, we find the goals of sections 254(b) and 254(h) are best served by prioritizing both RHC Programs according to degree of rurality and medical need, rather than arbitrarily prioritizing one program over another.

128. We also decline to prioritize funding based on the type of service, e.g., whether the support sought is for a monthly recurring service charge versus a one-time upfront payment, such as for infrastructure. Support of infrastructure and equipment costs are only available under the Healthcare Connect Fund Program so trying to prioritize by service raises the same issues as prioritizing one program over another.<sup>383</sup> We intend to treat both programs equally and to provide applicants the necessary flexibility to choose the services and infrastructure that best satisfy their needs in a given funding year without concern over losing funding priority. We recognize this approach deviates from that taken under the E-Rate Program but find this is the right approach for the RHC Program at this time.<sup>384</sup>

129. Below is a breakdown of the health care provider sites and amounts committed for funding year 2017 as compared to the prioritization categories adopted. As this table shows, a large portion of the sites and funding fall within the highest category, Priority 1. The table also highlights that in funding year 2017, a significant amount of funding went to sites in non-rural areas as part of consortia in the Healthcare Connect Fund Program. These sites will now be deprioritized and could receive less funding than sites in rural areas if demand exceeds available funds.

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Healthcare Connect Fund Program is statutorily limited to advanced telecommunications services and information services. 47 U.S.C. § 254(h)(1)(A), (2)(A). The overlap diminishes somewhat the technology benefits of favoring one program over the other and would instead just shift the amount of the discount provided to each health care provider under the two different programs in a prioritization scheme based on program type.

<sup>380</sup> See GCI Comments at 49 (stating that Telecom and Healthcare Connect Fund Programs should receive equal treatment); SpaceX Comments at 6 (supporting equal treatment of programs).

<sup>381</sup> See ACS Comments at 37.

<sup>382</sup> See 47 U.S.C. § 254(h)(1)(A).

<sup>383</sup> See *Universal Service Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18781, at para. 40 (“Section 254(h)(1)(A) does not authorize the provision of universal service support for equipment needed by rural health care providers to establish telemedicine programs.”); *Universal Service First Report and Order*, 12 FCC Rcd at 9109, para. 634 (holding “‘infrastructure development is not a ‘telecommunications service’ within the scope of section 254(h)(1)(A)’”).

<sup>384</sup> We note the E-Rate Program includes a larger universe of urban sites, does not have two separate sub-programs for support, and is further along on the development/adoption cycle than the RHC Program. Accordingly, the goals served by prioritizing based on categories of services in the E-Rate Program does not directly translate to the RHC Program at this time.



Table 3: Allocation of Funding Year 2017 Commitments in Prioritization Categories<sup>385</sup>

HCP Site is located in:	MUA/P	Number of HCP Sites	Committed Funding Amount	Not in MUA/P	Number of HCP Sites	Committed Funding Amount (\$)
<i>Extremely Rural Tier</i>	<i>Priority 1</i>	2,782	\$139,495,781	<i>Priority 4</i>	701	\$20,254,621
<i>Rural Tier</i>	<i>Priority 2</i>	955	\$27,694,946	<i>Priority 5</i>	716	\$17,789,469
<i>Less Rural Tier</i>	<i>Priority 3</i>	1,200	\$36,501,369	<i>Priority 6</i>	828	\$20,283,456
<i>Non-Rural Areas</i>	<i>Priority 7</i>	831	\$47,308,989	<i>Priority 8</i>	1,311	\$70,544,242

#### 4. Miscellaneous

130. *Retaining the Current Definition for Rural Area.* In the 2017 *Promoting Telehealth Notice and Order*, the Commission sought comment more generally on whether to modify the broader definition of “rural area” in the Commission’s rules.<sup>386</sup> A change in the definition would go beyond any prioritization process and would alter eligibility to participate in the RHC Program altogether.<sup>387</sup> We agree with commenters that modification of the definition is unwarranted at this time and could cause uncertainty for program recipients.<sup>388</sup> That said, we will add to the definition as necessary to reflect the three different rurality tiers discussed herein, which has relevance for not only prioritization but also for the determination of rates for comparable rural areas in a state. This change will not result in a substantive modification of the definition for rural area for eligibility purposes, however.<sup>389</sup>

131. There is no evidence in the record to indicate the definition is not working as intended to identify rural areas for program eligibility and support.<sup>390</sup> Accordingly, we find no reason to alter the definition this time. Broadening the definition as suggested by some commenters<sup>391</sup> would expand the

<sup>385</sup> *RHC Program Open Data Platform*.

<sup>386</sup> 47 CFR § 54.600(b); 2017 *Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10643-44, para. 30.

<sup>387</sup> Only “rural health care providers” may request support under the Telecom Program. 47 CFR § 54.602(a). A rural health care provider is “an eligible health care provider site located in a rural area” as defined by the Commission’s rules. 47 CFR § 54.600(c). Only a rural health care provider may receive support through the Healthcare Connect Fund Program unless the health care provider participates in a qualifying consortium. 47 CFR § 54.630.

<sup>388</sup> See ACS Reply Comments at 46; CHC Comments at 1; KSLLC Comments at 7; KSLLC Reply Comments at 8; see also AAFP Comments at 1 (encouraging consistency in the definition of “rural” in the federal government, unless there is a demonstrable reason to deviate).

<sup>389</sup> Following the release of the initial draft of this Report and Order, some parties claim the actions taken herein would now mean certain small towns would be considered non-rural. SOHCN July 23, 2019 *Ex Parte* Letter at 1; SHLB July 22, 2019 *Ex Parte* Letter at 2. However, our actions in this Report and Order in no way alter the current definition of rural area for the purposes of eligibility. Accordingly, small towns not currently falling within the definition of a rural area and those communities currently considered rural will continue to be treated as such.

<sup>390</sup> SOHCN states the 25,000 population threshold contained in the definition of rural area for determining rural and non-rural areas is too low but fails to provide support for this position or explain why the Commission’s initial determination for this threshold was flawed. SOHCN July 23, 2019 *Ex Parte* Letter, Attach., at 4. Accordingly, we decline at this time to revise the population threshold for determining rural areas.

<sup>391</sup> AHA Comments at 16; NHeLP Comments at 5 (suggesting the Commission use the Census Bureau’s Urban Area and Urban Cluster designations, which some experts say tend include suburban areas as rural, to define rural areas); see also HRSA, *Defining Rural Population* (Dec. 2018), <https://www.hrsa.gov/rural-health/about-us/definition/index.html> (discussing methodologies for determining rural areas by different agencies).

universe of potential applicants at a time when the Commission is already faced with demand outpacing available funds in recent years. This could lead to even more applicants seeking limited funding, placing even more pressure on administrative resources and increasing the likelihood of unfulfilled expectations by applicants, especially with the Commission replacing proration with prioritization. Conversely, narrowing the definition could lead many currently eligible participants to become ineligible for support and significantly impacting their ability to deliver needed health care services to patients in a given area. Given the potential disruptions and complications by altering the definition of rural areas, we find the better course is to evaluate the impact of the reform measures adopted in this Report and Order on the program before making further changes to the definition.

132. We are sympathetic to those commenters desiring consistency across federal agency programs on the methodology for determining rural areas.<sup>392</sup> The Commission did previously follow the definition used by the Federal Office of Rural Health Policy (FORHP) but made a change in 2004 when the methodology used to identify rural areas within Metropolitan Statistical Areas was altered to rely on Rural Urban Commuting Area codes.<sup>393</sup> We recognize most of the Commission's reason for not continuing to follow the FORHP standard have since been resolved.<sup>394</sup> That said, we find the better course at this time is to retain the Commission's current definition. We will, however, continue to evaluate the rural area methodologies used by FORHP and other federal agencies.

133. Separately, with the 2020 decennial census approaching, we remind program participants of the procedures previously outlined to address revisions to the list of eligible rural areas (Rural Areas List).<sup>395</sup> In addition, we take this opportunity to make one minor change to those procedures. Specifically, to simplify and minimize disruptions in between decennial data releases and the corresponding Core Based Statistical Area designation updates, we instruct the Administrator to only refresh the Rural Areas List when the decennial census data and Core Based Statistical Area designations based on the new decennial census data are released.<sup>396</sup> The Administrator should not update the Rural

<sup>392</sup> See SHLB Comments at 16-17; SOHCN Reply Comments at 6; TAHC Reply Comments at 1.

<sup>393</sup> *Rural Health Second Report and Order*, 19 FCC Rcd at 24617-24, paras. 9-23. The Federal Office of Rural Health Policy within the Health Resources & Services Administration developed Rural Urban Commuting Area codes in collaboration with the U.S. Department of Agriculture's Economic Research Service. The codes "are a Census tract-based classification scheme that use Census Bureau Urbanized Areas and Urban Clusters in combination with commuting information to characterize all of the nation's census tracts regarding their rural and urban status and relationships." Rural Health Information Hub, *What are RUCA codes?* (Feb. 8, 2018), <https://www.ruralhealthinfo.org/topics/what-is-rural#goldsmith-modification>.

<sup>394</sup> Two of the main reasons why the Commission declined to use Rural Urban Commuting Area codes in 2004 were: (1) the potential disadvantaging of areas in large census tracts in western states deemed non-rural; and (2) failure to incorporate the most recent census data. *2004 Report and Order*, 19 FCC Rcd at 24622-23, para. 20. The Federal Office of Rural Health Policy has since made changes to resolve these concerns. See, e.g., HRSA, Federal Office of Rural Health Policy, *Defining Rural Population* (Dec. 2018), <https://www.hrsa.gov/rural-health/about-us/definition/index.html> ("In response to these concerns, the Federal Office of Rural Health Policy has designated 132 large area census tracts with RUCA codes 2 or 3 as rural. . . . Following the 2010 Census the Federal Office of Rural Health Policy definition included approximately 57 million people, about 18% of the population.").

<sup>395</sup> See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 29 FCC Rcd 8609 (WCB 2014) (2014 Order); USAC, *Eligible Rural Areas Search*, <https://www.usac.org/rhc/telecommunications/tools/Rural/search/search.asp> (last visited July 2, 2019). The Rural Areas List is based on the Commission's current definition for rural areas, which relies on decennial census data and the Office of Management and Budget's Core Based Statistical Area designations, which are also updated to reflect the most recent decennial census data.

<sup>396</sup> The 2014 Order suggested the Administrator should update the list annually to reflect periodic updates between decennial releases. *2014 Order*, 29 FCC Rcd at 8611-12, para. 6 n.23. This could result in year-to-year uncertainty for participants as to whether a particular area remains eligible.

Areas List in between the decennial updates to reflect periodic data refreshes. For example, the Administrator should not update the list to reflect the ongoing American Community Survey that occurs in between decennial updates. While this means the Rural Areas List will not be based on the most up-to-date data each year, it will simplify the process and minimize potential disruptions for program participants in between decennial releases.

134. *Funding Is Not without Limit.* The Telecom Program is rooted in section 254(h)(1)(A).<sup>397</sup> The Commission has previously read this language to mean the “amount of credit or reimbursement to carriers from the health care support mechanism is based on the difference between the price actually charged to eligible health care providers [i.e., the discounted urban rate] and the rates for similar, if not identical, services provided to ‘other customers’ in rural areas in that State.”<sup>398</sup> Several commenters argue this statutory language requires the Commission to fully fund without limit all requests for commitments under the Telecom Program.<sup>399</sup> We disagree.

135. Section 254(h)(1)(A) does not expressly provide for the creation of a funding support mechanism for telecommunications services to rural health care providers, but the Commission has relied on this provision to create the Telecom Program. Prior to creation of the Telecom Program, the Joint Board recommended the Commission rely on offsets and “disallow the option of direct reimbursement” given the statutory language to treat the discounted amount “as a service obligation as part of [the carrier’s] obligation to participate in the mechanisms to preserve and advance universal service.”<sup>400</sup> The Commission instead allowed for direct compensation when and if the amount of discounted services provided exceeded the provider’s Universal Service Fund contribution.<sup>401</sup> In 2012, the Commission changed its rules to “permit USF contributors in the Telecommunications Program and the Healthcare Connect Fund to elect whether to treat the amount eligible for support as an offset against their universal service contribution obligation, or to receive direct reimbursement from USAC.”<sup>402</sup>

136. The Commission has never treated the section 254(h)(1)(A) provision as creating an unlimited right to Universal Service Fund support for telecommunication services provided to rural health care providers. As discussed above, the Commission adopted a \$400 million cap in 1997 on the Telecom Program in order to “control the size of the support mechanism” and “to fulfill [its] statutory obligation to create specific, predictable, and sufficient universal service support mechanisms.”<sup>403</sup> The following year, the Commission adopted a proration mechanism should demand ever exceed the cap.<sup>404</sup> The Commission would not have adopted a cap or a proration mechanism if it believed that it lacked statutory authority to set limits on the Telecom Program, which was implemented by section 254(h)(1)(A). The Commission has also placed other limitations on support provided under section 254(h)(1)(A). When creating the Telecom Program in 1997, the Commission also limited services eligible for support to services with a

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<sup>397</sup> Section 254(h)(1)(A) states: “A telecommunications carrier providing service under this paragraph *shall be entitled* to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service.” 47 U.S.C. § 254(h)(1)(A) (emphasis added).

<sup>398</sup> See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Notice of Proposed Rulemaking, 11 FCC Rcd 18092, 18137, para. 101 (1996).

<sup>399</sup> See ACS Reply Comments at 45; GCI Comments at 42; TeleQuality Comments at 9.

<sup>400</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 9154, para. 733.

<sup>401</sup> *Id.* at 9154-55, para. 734.

<sup>402</sup> *Healthcare Connect Fund Order*, 27 FCC Rcd at 16825, para. 372.

<sup>403</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 9140-41, para. 704.

<sup>404</sup> *1998 Proration Order*, 13 FCC Rcd at 14940, paras. 39-40.

bandwidth equal to or less than 1.544 Mbps per location, finding telecommunications services in excess of this threshold “not necessary for the provision of health care services at th[at] time.”<sup>405</sup> Faced with tepid participation in the program, in 1999 the Commission eliminated the per-location limit and the limitation on service bandwidth finding such restrictions “no longer necessary to ensure that demand for support remains below the . . . per year cap.”<sup>406</sup>

137. Congress intended section 254(h) “to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the nation.”<sup>407</sup> The language of section 254(h) provides the Commission with ample flexibility on how to structure a support mechanism to further this goal. As with any support mechanism, the Commission must base its decisions on the principles set forth in section 254(b), including having “specific, predictable, and sufficient Federal and State mechanisms to preserve and advance universal service.”<sup>408</sup> The prioritization approach adopted herein serves this principle. Allowing funding without any limit runs counter to fiscal responsibility. We do not believe Congress intended such a result, and instead conclude that Congress has given the Commission the necessary tools to preserve and advance universal service, including the ability to place limits on the amount of funding available.

138. *Maintaining the Funding Cap on Multi-Year Commitments and Upfront Payments and Instituting an Inflation Adjustment.* We retain the \$150 million cap on multi-year commitment and upfront payment requests in the Healthcare Connect Fund Program,<sup>409</sup> but provide for the cap to be adjusted annually for inflation.<sup>410</sup> The \$150 million funding cap on multi-year and upfront payment requests has only been exceeded once since its creation in 2012.<sup>411</sup> In funding year 2018, gross demand for multi-year commitments and upfront payments was \$237 million, and demand for remaining Healthcare Connect Fund Program requests and Telecom Program requests was approximately \$411 million.<sup>412</sup> The overall program funding cap for funding year 2018 was approximately \$581 million.<sup>413</sup> If not for the \$150 million cap on multi-year commitment and upfront payment requests, all funding year 2018 requests would have had to be prorated to bring the \$648 million total gross demand for RHC Program funding below the \$581 million funding cap, resulting in reductions of funding for *all* program

<sup>405</sup> 47 U.S.C. § 254(h)(1)(A); *Universal Service First Report and Order*, 12 FCC Rcd at 9132, para. 684.

<sup>406</sup> See *Universal Service Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18767-70, at paras. 17, 20-22.

<sup>407</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 9093-94, para. 610; Joint Explanatory Statement at 132.

<sup>408</sup> 47 U.S.C. § 254(b)(5).

<sup>409</sup> 47 CFR § 54.674(a); *Healthcare Connect Fund Order*, 27 FCC Rcd at 16802, para. 298 (“We institute a single cap of \$150 million that will apply to all commitments for upfront payments during the funding year, and all multi-year commitments made during a funding year.”).

<sup>410</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10640, paras. 17-18 (seeking comment on whether to adjust the \$150 million funding cap by increasing it, eliminating it, or modifying it in “some other way”); *2018 Report and Order*, 33 FCC Rcd at 6580, para. 13 & n.44 (“We plan to consider whether to increase the internal \$150 million cap at a future time . . .”).

<sup>411</sup> See *2019 Order* at \*2, para. 6.

<sup>412</sup> *Id.* The \$237 million demand for multi-year and upfront payment requests in funding year 2018 represents an approximate \$94 million increase in demand from funding year 2017. *USAC Data Submission* at Appx. A, p. 5.

<sup>413</sup> Per the Commission’s rules, the annual funding cap is \$571 million, which is then adjusted annually for inflation. 47 CFR § 54.675(a)(1); see *2018 Report and Order*, 33 FCC Rcd at 6584, para. 23 (“For FY 2018, based on GDP-CPI, the RHC Program funding cap will be \$581 million.”).

participants.<sup>414</sup> Because the \$150 million cap on multi-year and upfront requests was in place, the Administrator was able to process single-year funding year 2018 requests at their full eligible amounts.<sup>415</sup> Stated differently, the \$150 million cap did the job the Commission intended when it was established – to prevent multi-year and upfront payment requests from usurping the funding available for single-year requests for recurring services and safeguard against large fluctuations in demand for RHC Program funds.<sup>416</sup> Absent additional data demonstrating the need to increase the \$150 million cap (if it is exceeded in future funding years), providing an economic basis for a particular increase amount, and establishing that an increase would not have a detrimental impact on single-year requests, we conclude that increasing the base amount of the \$150 million cap on multi-year commitments and upfront payments would not be a fiscally responsible measure consistent with our obligation to be good stewards of the Universal Service Fund.

139. That said, we conclude that the \$150 million funding cap on multi-year and upfront payment requests should be adjusted annually for inflation. In the *2018 Report and Order*, we found that health care providers purchasing services with RHC Program support should be able to maintain consistent purchasing power in the event of price inflation.<sup>417</sup> To provide the flexibility necessary for that to occur, we adopted a rule that annually adjusts the overall RHC Program cap for inflation, using the GDP-CPI inflation index.<sup>418</sup> We find that adjusting the \$150 million funding cap on multi-year commitments and upfront payments within the Healthcare Connect Fund Program by the same index is a fiscally responsible means of preventing inflation from eroding the purchasing power of health care providers seeking such requests without overburdening the Universal Service Fund, unreasonably increasing contribution charges passed through to consumers, or risking an untenable depletion of funding available for single-year requests. We direct the Wireline Competition Bureau to compute the annual inflation adjustment pursuant to the same criteria established for adjusting the overall RHC Program funding cap in the *2018 Report and Order*.<sup>419</sup> Any increases to the \$150 million funding cap will be accounted for *within* the overall RHC Program cap, i.e., an increase in the \$150 million funding cap on multi-year commitments and upfront payments will not increase the overall RHC Program cap. We direct the Wireline Competition Bureau to announce any inflation-adjusted increase in the \$150 million funding cap on multi-years and upfront payments in the same Public Notice that announces the inflation adjustment of the overall cap,<sup>420</sup> if any.

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<sup>414</sup> See *2019 Order* at \*2, para. 4 (explaining that, after a filing window period closes, the Commission requires the Administrator to prorate funding requests to ensure that commitments do not exceed the overall RHC Program funding cap or the \$150 million cap on multi-year and upfront payment requests).

<sup>415</sup> See *2019 Order* at \*2, para. 7.

<sup>416</sup> *Healthcare Connect Fund Order*, 27 FCC Rcd at 16801-02, paras. 296, 298 (“This cap takes into account the need for economic reasonableness and responsible fiscal management of the program . . .”). We note that the entire amount of a multi-year commitment counts against the funding cap for the funding year in which it is committed. *Id.*

<sup>417</sup> *2018 Report and Order*, 33 FCC Rcd at 6583, para. 21.

<sup>418</sup> 47 CFR § 54.675(a)(1), (2).

<sup>419</sup> *Id.*; *2018 Report and Order*, 33 FCC Rcd at 6583, para. 23. The GDP-CPI inflation index will be used to adjust the \$150 million funding cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program. To compute the annual inflation adjustment, the percentage increase in the GDP-CPI from the previous year will be used. The increase shall be rounded to the nearest 0.1%. The increase in the inflation index will then be used to calculate the maximum amount of funding for the next RHC Program funding year which runs from July 1 to June 30. In the event of periods of deflation, the cap on multi-year commitments and upfront payments for the prior funding year will be used to maintain predictability.

<sup>420</sup> 47 CFR § 54.675(a)(3).



140. We appreciate that health care providers want certainty of funding approvals when applying for multi-year commitments and upfront payments. The reality of the RHC Program and other universal service mechanisms is that available funds are limited, however, and there is no guarantee that funding requests submitted to the Administrator in a particular funding year will be approved. We note that the inability to obtain a multi-year *commitment* from the RHC Program due to a lack of available funds in a particular funding year does not prevent health care providers from obtaining the benefits of a multi-year *contract*. Health care providers remain free to seek advantageous pricing through multi-year service arrangements and seek evergreen treatment of those contracts so that funding requests may be submitted to the Administrator for each year of the contract without rebidding the services.<sup>421</sup> Indeed, multi-year commitments are not permitted in the E-Rate Program,<sup>422</sup> but that does not prevent schools and libraries from benefitting from the cost-benefits of negotiating multi-year contracts for services, including substantial broadband projects.<sup>423</sup> Applicants that are concerned that a multi-year commitment may be denied in a particular funding year due to lack of funding should consider seeking annual funding for services provided under multi-year contracts.

141. *Clarifying the Carry-Forward Process for the RHC Program.* In June 2018, the Commission adopted rules to address increasing demand in the RHC Program.<sup>424</sup> Specifically, the Commission: (1) increased the annual RHC Program funding cap to \$571 million and applied it to funding year 2017; (2) provided for the annual RHC Program funding cap to be adjusted for inflation, beginning with funding year 2018;<sup>425</sup> and (3) established a process to carry-forward unused funds from past funding years for use in future funding years.<sup>426</sup> As part of that process, the Commission committed to announcing in the second quarter of each calendar year “a specific amount of unused funds from prior funding years to be carried forward to increase available funding for future funding years.”<sup>427</sup> The Commission indicated unused funds “may be used to commit to eligible services in excess of the annual funding cap in the event demand in a given year exceeds the cap, or it may be used to reduce collection for the RHC Program in a year when demand is less than the cap.”<sup>428</sup> The Commission directed the Wireline Competition Bureau to “announce the availability and amount of carryover funds during the second quarter of the calendar year.”<sup>429</sup>

142. To provide additional clarity for the carry-forward process, we direct the Wireline Competition Bureau, in consultation with the Office of the Managing Director, to determine the proportion of unused funding for use in the RHC Program in accordance with the public interest to either satisfy demand notwithstanding the annual cap, reduce collections for the RHC Program, or to hold in reserve to address contingencies for subsequent funding years. The Wireline Competition Bureau has authority to direct the Administrator to carry out the necessary actions for the use of available funds

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<sup>421</sup> 47 CFR § 54.642(h)(4)(ii); *Wireline Competition Bureau Provides Clarification Regarding Evergreen Contract Endorsements Under the Telecommunications and Healthcare Connect Fund Programs of the Rural Healthcare Support Mechanism*, WC Docket No. 02-60, Public Notice, 30 FCC Rcd 7258 (WCB 2015).

<sup>422</sup> 47 CFR § 54.507(d).

<sup>423</sup> See *Request for Review of the Decision of the Universal Service Administrator by Brooklyn Public Library, Changes to the Board of Directors of the National Exchange Carrier Association*, CC Docket 96-45 et al., Order, 15 FCC Rcd 18598, 18605-08, paras. 15-23 (2000).

<sup>424</sup> *2018 Report and Order*, 33 FCC Rcd 6574.

<sup>425</sup> The RHC Program funding year runs from July 1 to June 30 of the subsequent calendar year.

<sup>426</sup> 47 CFR § 54.675(a).

<sup>427</sup> *2018 Report and Order*, 33 FCC Rcd at 6584, para. 27.

<sup>428</sup> *Id.* at 6584-85, para. 27.

<sup>429</sup> *Id.*

consistent with the direction specified herein. The Commission previously provided similar authority to the Wireline Competition Bureau in the context of allocating unused funding between demand for Category 1 and 2 services for the E-Rate Program.<sup>430</sup>

143. *Targeting Support to Tribal Health Care Providers.* We specifically sought comment on targeting more support to health care providers located on Tribal lands and asked how our prioritization proposals would impact Tribal populations.<sup>431</sup> We received several comments on this issue, including comments from the Alaska Native Tribal Consortium and the Council of Athabascan Tribal Governments.<sup>432</sup> Commenters generally emphasized the need for Tribal consultation and supported funding for health care providers on Tribal lands, specifically supporting prioritization based on the most rural areas.<sup>433</sup> We believe the prioritization approach adopted herein, which prioritizes funding in those most rural areas with the greatest medical shortages, will help those living and seeking health care on Tribal lands as they are likely often the most remote and medically underserved areas of the country.

#### C. Increasing Rural Participation in Healthcare Connect Fund Program Consortia

144. The Healthcare Connect Fund Program provides support for eligible non-rural health care providers in majority-rural consortia.<sup>434</sup> Although the focus of the Healthcare Connect Fund Program is to support eligible rural health care providers, the Commission has recognized that eligible non-rural health care provider participation in consortia confers benefits upon affiliated rural health care providers, including lower broadband costs, access to medical specialists, administrative support, and technical expertise.<sup>435</sup> Under current rules, a Healthcare Connect Fund Program consortium must be comprised of “more than 50% rural health care providers.”<sup>436</sup> Consortia have three years from the filing date of their first funding request under the Healthcare Connect Fund Program to meet the majority-rural requirement.<sup>437</sup>

145. In funding year 2018, total gross demand for Healthcare Connect Fund Program consortia exceeded 50% of total RHC Program gross demand.<sup>438</sup> The percent of funding committed to eligible non-rural health care providers as part of consortia has been increasing year-over-year.<sup>439</sup> In funding year 2017, funding commitments to eligible *non-rural* health care providers in the Healthcare Connect Fund Program consortia equaled 54%, more than half of Healthcare Connect Fund Program consortia committed funding.<sup>440</sup> This is so even with the RHC Program limit on support to large non-rural public or non-profit health care providers—i.e., hospitals with 400 beds or more—which seeks to ensure the RHC

<sup>430</sup> See 47 CFR § 54.507(a)(5).

<sup>431</sup> 2017 *Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10646-47, para. 40.

<sup>432</sup> See ANTCH Comments at 1; CATG Comments at 1.

<sup>433</sup> See ANTCH Comments at 3; BBAC Comments at 6-7; KSLLC Comments at 10; NSCH Comments at 4; SCF Comments at 4; CATG Comments at 6; USF Consultants Comments at 1, 3.

<sup>434</sup> See 47 CFR § 54.630(b).

<sup>435</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16696, 16705-07, paras. 34, 60.

<sup>436</sup> See 47 CFR § 54.630(b); see also *Healthcare Connect Fund Order*, 27 FCC Rcd at 16707, para. 61. As of the adoption of the *Healthcare Connect Fund Order*, non-rural health care provider sites that received funding commitments through the Pilot Program in consortia that did not meet the more than 50% rural-majority were “grandfathered” – that is, these consortia were not required to meet the then-new majority-rural requirement. *Healthcare Connect Fund Order*, 27 FCC Rcd at 16707, para. 62.

<sup>437</sup> *Healthcare Connect Fund Order*, 27 FCC Rcd at 16707, para. 61.

<sup>438</sup> See *USAC Data Submission* at Appx. A, p. 4.

<sup>439</sup> *Id.*

<sup>440</sup> *Id.*

Program maintains its focus on smaller health care providers that serve predominantly rural populations.<sup>441</sup> We are concerned that with gross demand exceeding the RHC Program cap in recent years, this level of committed funding to eligible sites in non-rural areas runs counter to the intent of Congress to assist eligible health care providers in rural areas.

146. One problem appears to be the lengthy grace period for consortia. In funding year 2017, a full third of all consortia did not meet the majority-rural requirement. Funding year 2018 was no better—one third of all consortia still did not meet the majority-rural requirement.<sup>442</sup> The continued prevalence of majority-urban consortia helps explain why in funding year 2017 more than half of commitments to consortia went to non-rural health care providers<sup>443</sup> and almost one third of all dollars in the entire RHC Program in funding year 2017 went to urban areas<sup>444</sup>—where rates for communications services are decidedly lower. It is no surprise that some commenters support shortening the grace period to one year,<sup>445</sup> while others argue we should eliminate the grace period entirely.<sup>446</sup>

147. To ensure that eligible rural health care providers are benefiting from limited RHC Program dollars, we eliminate the three-year grace period for consortia to come into compliance with the majority-rural rule. We conclude that the Commission’s prior rationale for a three-year grace period are no longer applicable to the RHC Program as it exists today. It was established at the time when there was significantly less demand for RHC Program funding and the Commission sought to encourage the formation of consortia within the Healthcare Connect Fund Program. Now, approximately seven years later, circumstances have changed. The Healthcare Connect Fund Program is no longer in its infancy and demand for Healthcare Connect Fund Program support now exceeds Telecom Program demand.<sup>447</sup> Our focus now is to ensure that the limited RHC Program funding reaches the rural beneficiaries the RHC Program was created to support, and we determine that requiring all Healthcare Connect Fund Program consortia to comply with the majority-rural requirement is an appropriate step toward achieving those ends.

148. Eliminating the grace period (rather than shortening it) will also eliminate administrative burdens for the Commission and the Administrator in overseeing it—and eliminate an opportunity for regulatory arbitrage. No longer, for example, would the Administrator need to track how long a consortium had failed to meet the majority-rural requirement. And no longer would the Commission potentially face thorny compliance questions, such as whether a “new” consortium consisting of non-rural health care providers that switched from other non-compliant consortia would receive a new grace period.

149. We require all consortia to comply with the majority-rural requirement by funding year 2020.<sup>448</sup> Although we recognize that some existing consortia may need a slight ramp-up period to

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<sup>441</sup> 47 CFR § 54.630(c); *Healthcare Connect Fund Order*, 27 FCC Rcd at 16708, para. 64 (limiting non-rural hospitals with 400 or more licensed patient beds to no more than \$30,000 per year in support for recurring charges and no more than \$70,000 in support for nonrecurring charges every five years, exclusive in both cases of costs shared by the network).

<sup>442</sup> See *USAC Data Submission* at Appx. A, p. 5.

<sup>443</sup> *Id.* at Appx. A, p. 4.

<sup>444</sup> See Table 3, *supra*. Indeed, that table shows that health care providers from medically served, urban areas were the second largest category of providers in the RHC Program, both in terms of number of applicants and dollars committed.

<sup>445</sup> See CAH Comments at 2; CHC Comments at 2.

<sup>446</sup> See ACS Comments at 36; NACHC Comments at 19; NOSORH Comments at 4.

<sup>447</sup> See *supra* Figs. 1 and 2.

<sup>448</sup> Funding requests filed by consortia that are not in compliance with the majority-rural threshold at the time the funding request is submitted will be denied.

negotiate and enter into contractual relationships amongst their participants and form a technology plan, almost two out of every three consortia have already demonstrated that achieving more than 50% rural participation is feasible—and 37% of consortia have reached at least 75% rural participation.<sup>449</sup> For those that have not yet met the 50% threshold, we find that allowing them until funding year 2020 to reach it strikes the appropriate balance between ensuring that RHC Program support reaches eligible non-rural health care providers during the transition to majority-rural status and the Commission’s duty to ensure that RHC Program support is focused on the delivery of services to eligible health care providers in rural areas. For new consortia seeking to participate in the Healthcare Connect Fund Program, the majority-rural threshold must be met at the time that they apply for RHC Program funding. And while Kellogg & Sovereign, LLC asserts that, in some circumstances, it can take up to three years “to establish the contracts” to initiate the consortium and to add the eligible rural health care providers to “ensure a proper balance,”<sup>450</sup> we do not see that as a reason to steer scarce RHC Program funds to non-compliant consortia when so many rural health care providers as well as compliant consortia are in need.

150. Given our elimination of the grace period, we decline to increase the majority-rural threshold at this time.<sup>451</sup> Rather, we determine that increases to the majority-rural threshold should be consistent with overall RHC Program demand and the need to prioritize funding to health care providers in rural areas. Accordingly, we will increase the majority-rural consortia percentage requirement only when RHC Program demand exceeds the funding cap. Specifically, if we must prioritize funding in one year because demand exceeds the cap, the majority-rural threshold will automatically increase by 5% for the following funding year (up to a maximum of 75%). Consistent with our statutory mandate, this will ensure, as demand increases, that more Healthcare Connect Fund Program funding is focused on eligible health care providers serving rural areas. And although some commenters argue for an immediate increase of the requirement,<sup>452</sup> we find that our more incremental approach—making such increases only when further evidence of demand outstripping supply comes in—better accomplishes the goals of such commenters without preemptively limiting participation by currently compliant consortia.

151. We are not persuaded by commenters who oppose increasing the majority-rural health care provider requirement for Healthcare Connect Fund Program consortia. These commenters argue that: (1) the rural/non-rural composition of consortia is artificial;<sup>453</sup> (2) increasing the majority-rural requirement may prevent small consortia from participating;<sup>454</sup> (3) non-rural health care providers that deliver institutional knowledge, specialization, and expertise to rural communities may be disincentivized from participating;<sup>455</sup> and (4) non-rural participants help to offset the expense of middle- and last-mile costs.<sup>456</sup> Based on RHC Program data, the majority of consortia currently participating in the Healthcare

<sup>449</sup> See *USAC Data Submission* at Appx. A, p. 5 (in funding year 2018, 66% of consortia met or exceeded the 50% rural health care provider threshold, while 40% met or exceeded 75% rural health care provider participation).

<sup>450</sup> See KSLLC Comments at 10.

<sup>451</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10645-46, paras. 35-36.

<sup>452</sup> See USTelecom Comments at 24-5 (advocating for a more than 75% majority-rural rule in an effort to “ensure that the overall focus of the consortia targets rural healthcare providers”); NACHC Comments at 19 (advocating for majority-rural threshold of a “minimum of 75%” to prevent non-rural consortia participants from receiving more funding than the rural health care providers); NOSORH Comments at 4 (funding to non-rural consortia participants should not exceed the total support provided to the rural consortia participants). We are not persuaded by ACS’s argument that non-rural consortia participants should receive no funding. ACS Comments at 35-6. As discussed above, eligible non-rural health care providers’ participation in consortia provide benefits to the participating rural health care providers.

<sup>453</sup> See WNY R-AHEC Comments at 1.

<sup>454</sup> See KSLLC Comments at 9.

<sup>455</sup> See AHA Comments at 13; NETC Comments at 4.

<sup>456</sup> See SHLB Comments at 29-30; SHLB Reply Comments at 10.

Connect Fund Program exceed the current majority-rural participation requirement without any apparent degradation of benefits to the eligible rural health care participants.<sup>457</sup> We determine based on the current make-up of participating consortia, and with no data to support the arguments of the commenters opposing an increase, that increasing the majority-rural requirement by an incremental percentage as demand exceeds the cap, focuses our limited RHC Program dollars on support for eligible rural health care providers while still encouraging the participation of eligible non-rural health care providers. Thus, we require all existing and new consortia to reach any increased threshold, as necessary, and in so doing ensure the focus of RHC Program support remains primarily on supporting eligible rural health care providers.

152. *Applicability to Grandfathered Pilot Program Consortia.* The rule changes we adopt herein will apply equally to those consortia that participated in the prior Pilot Program and were grandfathered from complying with the majority-rural requirement in 2012.<sup>458</sup> These grandfathered consortia were allowed to participate in the Healthcare Connect Fund Program with limitations on adding eligible non-rural member sites.<sup>459</sup> The Commission grandfathered these consortia in recognition of their ability to encourage eligible rural health care provider participation in the Healthcare Connect Fund Program, and to minimize potential disruption in rural health care as the Commission transitioned from a pilot to a permanent program.<sup>460</sup> Currently, 32 grandfathered Pilot Program consortia are participating in the Healthcare Connect Fund Program.<sup>461</sup> All but three of these consortia now have more eligible rural than non-rural sites, i.e., a rural majority.<sup>462</sup> Fourteen of the 32 grandfathered Pilot Program consortia consist of 75% or more eligible rural sites.<sup>463</sup> Given the limited number of such consortia and the current percentage of eligible rural health care provider sites within each consortia, we see no detrimental impact from requiring the remaining three consortia to meet the majority-rural requirement in one year. As indicated above, circumstances have changed significantly since the Commission decided to grandfather Pilot Program consortia in 2012. We therefore find all these requirements should apply equally to those grandfathered Pilot Program consortia.

#### **D. Increasing Effectiveness of Competitive Bidding**

153. Competitive bidding reinforces the Commission's goals for the RHC Program by ensuring that rural health care providers are aware of cost-effective alternatives.<sup>464</sup> In this section, we act on several proposals in the *2017 Promoting Telehealth Notice and Order* to bolster and align the Commission's competitive bidding rules for each RHC Program.<sup>465</sup> These revisions will also provide the Commission and the Administrator with greater means to ensure and verify that RHC Program participants are not engaging in fraudulent conduct or otherwise violating the Commission's competitive bidding rules.

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<sup>457</sup> See *USAC Data Submission* at Appx. A, p. 5.

<sup>458</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16707-08, para. 62 n.170.

<sup>459</sup> See *id.*

<sup>460</sup> *Id.* at 16710-11, para. 68.

<sup>461</sup> *RHC Program Open Data Platform.*

<sup>462</sup> *Id.*

<sup>463</sup> *Id.*

<sup>464</sup> See *Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 688. As discussed above, the rural rate determined by the Administrator represents a "ceiling," in that it establishes the maximum amount of support that the Commission will provide. However, Telecom Program participants are not required to use a median rural rate determined by the Administrator. They remain free to seek support for a lower rate provided that lower rate was competitively bid in a manner consistent with our competitive bidding rules. See *supra* para. 64.

<sup>465</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10657-61, 10663-66, paras. 82-93, 99-104.



## 1. Requiring Applicants to Seek Bids for Particular Services, Not Tasks Performed by a Service

154. Under our rules governing the Telecom Program and Healthcare Connect Fund Program, health care providers during the competitive bidding process are required to select the most “cost-effective” service offering.<sup>466</sup> As the Commission explained in the *2017 Promoting Telehealth Notice and Order*, the definition of “cost-effective” applicable to both RHC Programs places virtually no limitation on how health care providers make their service selection.<sup>467</sup> In addition, because the definition of “cost-effective” does not require health care providers to identify their specific service requirements when posting their requests for service, they can select carriers whose service offerings meet the current “cost-effective” definition, but which exceed the needs of the health care providers irrespective of cost.<sup>468</sup> The result is a procedure that can lead to wasteful inefficiency in the competitive bidding process.

155. To increase the effectiveness of the competitive bidding process, we implement a new safeguard intended to reduce the risk of the type of inefficiency described above. Specifically, we will require RHC Program applicants to list the requested services for which they seek bids (e.g., Internet access, bandwidth) rather than merely listing what those services are intended to do (e.g., transmit x-rays), and require applicants to provide sufficient information to enable bidders to reasonably determine the needs of the applicant and provide responsive bids.<sup>469</sup> Commenters offer broad support for the requirement that requests for services include greater specificity.<sup>470</sup> While commenters are generally supportive of requiring more specific descriptions of intended use of a requested service, we believe requiring applicants to describe with greater specificity the precise *services* that they need, rather than just more specific uses, will reduce the likelihood of funding being used for excessively expensive services that are not necessary. This in turn will ensure a more equitable distribution of limited RHC Program funding. This change will become effective for funding year 2020.

## 2. Harmonizing Certification and Documentation Requirements Between the RHC Programs

156. To further promote the effectiveness of the competitive bidding process, we harmonize our competitive bidding rules to require that Telecom Program applicants and Healthcare Connect Fund Program applicants submit the same certifications and documentation (with limited exceptions) as part of

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<sup>466</sup> See 47 CFR §§ 54.603(b)(4), 54.642(d).

<sup>467</sup> *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10657, para. 82. “Cost-effective” is defined as the “method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services.” 47 CFR §§ 54.603(b)(4), 54.642(c). This definition remains unchanged. See 47 CFR § 54.622(c), as adopted herein; Appx. A, Final Rules.

<sup>468</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10657-58, para. 83.

<sup>469</sup> 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules. Applicants will be required to include their bid evaluation criteria as part of their applications. 47 CFR § 54.622, as adopted herein; Appx. A. The FCC Form 461 and FCC Form 465 will be revised as necessary to reflect these new requirements.

<sup>470</sup> See, e.g., USTelecom Comments at 18 (suggesting that a meaningful bid evaluation and cost effectiveness review can be promoted with the inclusion of information such as desired resolution for video conferencing, the number of patients to be monitored simultaneously, the volume of files to be transmitted at peak hours, the types of equipment the health care provider intends to use, and any planned telemedicine capabilities or usage needs upgrades over the term of the contract); ACS Comments at 18 (citing the types of information noted by USTelecom and adding the level of security needed for transmission and whether cloud access is needed); SHLB Comments at 20; KSLLC Comments at 12; NCTA Comments at 2; AT&T Reply Comments at 12; TeleQuality Reply Comments at 5; INCOMPAS Reply Comments at 7.

their requests for service.<sup>471</sup> Commenters generally support the alignment of competitive bidding requirements between the two RHC Programs as a means of reducing administrative burdens.<sup>472</sup> We agree, and note further that requiring the same types of certifications and documentation across both programs will establish a standardized competitive bidding process that provides the Administrator with a uniform set of information necessary to protect against waste, fraud, and abuse.

157. We first harmonize the certifications that RHC Program applicants must make when requesting service. Effective with funding year 2020, both Telecom Program and Healthcare Connect Fund Program applicants will be required to provide, contemporaneously with their requests for services, the following identical certifications that: (1) the health care provider seeking supported services is a public or nonprofit entity that falls within one of the seven categories set forth in the definition of health care provider listed in section 54.600 of our rules; (2) the health care provider seeking supported services is physically located in a rural area as defined in section 54.600 of our rules, or is a member of a Healthcare Connect Fund Program consortium which satisfies the rural health care provider composition requirements set forth in section 54.607 of our rules; (3) the person signing the application is authorized to submit the application on behalf of the applicant, has examined the form and attachments, and to the best of his or her knowledge, information, and belief, all statements contained therein are true; (4) the applicant has complied with any applicable state, Tribal, or local procurement rules; (5) RHC Program support will be used solely for purposes reasonably related to the provision of health care service or instruction that the health care provider is legally authorized to provide under the law of the state in which the services will be provided and will not be sold, resold, or transferred in consideration for money or any other thing of value; (6) the applicant satisfies all requirements under section 254 of the Act and applicable Commission rules; and (7) the applicant has reviewed and is compliant with all applicable RHC Program requirements.<sup>473</sup> We will also require applicants of both RHC Programs to provide full details of any arrangement involving the purchasing of service or services as part of an aggregated purchase with other entities or individuals.<sup>474</sup>

158. In addition to the foregoing, we also harmonize and expand two key competitive bidding documentation requirements. Applicants of both RHC Programs currently submit with their requests for service weighted evaluation criteria (e.g., a scoring matrix) that demonstrate how the applicant will choose the most cost-effective bid and a declaration of assistance identifying each paid or unpaid consultant, vendor, and other outside expert who aided in the preparation of their applications. There are, however, no RHC Program-wide rules governing either type of documentation. We therefore amend our rules to codify the requirement that both Telecom Program and Healthcare Connect Fund Program applicants submit weighted bid evaluation criteria as before, but also specify on their bid evaluation worksheet/scoring matrix their minimum requirements for each criteria and record on their worksheet/matrix each service provider's proposed service levels for the established criteria.<sup>475</sup> We also

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<sup>471</sup> Healthcare Connect Fund Program applicants are required to provide certain documentation concerning requests for proposals and consortiums. 47 CFR § 54.642(e)(4), (5). These requirements will not apply to the Telecom Program.

<sup>472</sup> See YKHC Comments at 3 (aligning the documentation requirements between the Telecom Program and Healthcare Connect Fund Program will reduce the associated administrative burdens on resource-constrained health care providers); USTelecom Comments at 18; KSLLC Comments at 16; SHLB Comments at 20.

<sup>473</sup> 47 CFR § 54.623, as adopted herein; Appx. A, Final Rules. The first two certifications concerning public or nonprofit status and rural area location are currently not required of Healthcare Connect Fund Program applicants.

<sup>474</sup> 47 CFR § 54.623, as adopted herein; Appx. A, Final Rules. Telecom Program applicants are already required to certify as to the details provided regarding aggregated purchases. 47 CFR § 54.603(b)(vi).

<sup>475</sup> 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules. After reviewing the bid submissions and identifying the bids that satisfy the applicant's specified needs, the applicant must then select the service provider that offers the most cost-effective service. *Id.*

require applicants of both programs to specify their disqualification factors, if any, that they will use to remove bids or bidders from further consideration.<sup>476</sup>

159. We further amend our rules to codify the requirement that both Telecom Program applicants and Healthcare Connect Fund Program applicants submit a declaration of assistance identifying each paid or unpaid consultant, vendor, and other outside expert who aided in the preparation of their application.<sup>477</sup> In addition, to better safeguard against the possibility of conflicts of interest, we also require applicants to describe the nature of the relationship they have with any such outside entity identified in their declaration of assistance.<sup>478</sup> While cognizant of the additional time that these new requirements may require of health care providers preparing their requests, we conclude that any increased administrative burden will likely be minimal and offset by the increase in competitive bidding transparency and accountability.<sup>479</sup> The new documentation requirements discussed above will become effective for funding year 2020.

### **3. Extending Healthcare Connect Fund Program's "Fair and Open" Competitive Bidding Process to the Telecom Program**

160. To improve RHC Program uniformity and transparency, we align the "fair and open" competitive bidding standard applied in each program. While most Telecom Program participants already comply with this standard, and the Commission has long stated that an applicant must conduct a fair and open competitive bidding process,<sup>480</sup> there is no rule codifying this standard in the Telecom Program as

<sup>476</sup> 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules. As with the use of disqualification factors by applicants in the E-Rate Program, disqualification factors for RHC Program applicants must be clearly identified on the FCC Form 461 or FCC Form 465 (or RFP), must be determined prior to any substantive bid evaluation, and may not be scored on a sliding scale (i.e., the bid or bidder must either meet the standard or not). Examples of disqualification factors include requiring that the service provider register with the state procurement office, have a Service Provider Identification Number, and/or be bonded. See USAC, *How to Construct an Evaluation*, <https://www.usac.org/sl/applicants/step02/evaluation.aspx> (last visited July 2, 2019).

<sup>477</sup> 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules.

<sup>478</sup> 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules. See Part III.D.6 (discussing additional requirements applicable to the use of consultants).

<sup>479</sup> See NCTA Comments at 2-3 ("[A]ny modest cost increases for healthcare providers would be outweighed by the benefits of introducing additional accountability and transparency, as well as facilitating review by USAC and reducing complaints about the competitive bidding process."). Yukon-Kuskokwim Health Corporation urges the Commission "to be cautious in adopting new documentation requirements or similar bureaucratic burdens." YKHC Comments at 3. TeleQuality maintains that the Commission should strive to streamline the application process rather than require additional information. TeleQuality Comments at 23. Both parties share a concern that new documentation requirements may extend the already protracted funding decision process. We believe, however, that the reforms adopted herein will help to expedite that process by making funding decisions more standardized.

<sup>480</sup> See, e.g., *Universal Service First Report and Order*, 12 FCC Rcd at 9076, para. 480 (explaining that section 254(h) of the Act "compels" the Commission to require that eligible program participants seek competitive bids for all services eligible for section 254(h) discounts and that competitive bidding is the most efficient means for ensuring that eligible program participants are informed about all of the choices available to them). As noted above, the Telecom Program is rooted in section 254(h) of the Act. See 47 U.S.C. § 254(h); see also *Requests for Review of Decisions of the Universal Service Administrator by Hospital Networks Management, Inc.*, WC Docket No. 02-60, Order, 31 FCC Rcd 5731, 5740, para. 17 (WCB 2016) (*Hospital Networks Order*) (holding that an affiliation between an applicant's contact person and a prospective bidder undermines fair and open competitive bidding); *Schools and Libraries Universal Service Support Mechanism*, CC Docket Nos. 96-45, 97-21 and 02-6, Third Report and Order and Second Further Notice of Proposed Rulemaking, 18 FCC Rcd 26912, 26939, para. 66 (2003) (stating that a fair and open competitive bidding process is critical to preventing waste, fraud, and abuse of program resources); *Request for Review by Mastermind Internet Services, Inc.*, CC Docket No. 96-45, Order, 16 FCC Rcd 4028, 4033, para. 10 (2000) (*Mastermind Internet Services Order*) (holding that when the power of an applicant's contact person to disseminate information regarding the requested services is delegated to a service provider

(continued....)

there is in the Healthcare Connect Fund Program.<sup>481</sup> Generally, commenters support codifying this standard in the Telecom Program and argue that it should apply to all RHC Program participants, including applicants and service providers.<sup>482</sup>

161. We agree that this standard should apply to all participants in the RHC Program as it ensures that they are accountable for engaging in improper conduct that undermines the competitive bidding process or otherwise violates the Commission's rules.<sup>483</sup> We therefore amend the Commission's rules to codify the requirement that the Telecom Program competitive bidding process be "fair and open."<sup>484</sup> As proposed in the *2017 Promoting Telehealth Notice and Order*, we find that the following actions are necessary to satisfy the "fair and open" competitive bidding standard in each RHC Program: (1) all potential bidders and service providers must have access to the same information and must be treated in the same manner throughout the procurement process;<sup>485</sup> (2) vendors who intend to bid on supported services may not simultaneously help the applicant complete its request for proposal (RFP) or request for services form;<sup>486</sup> and (3) vendors who intend to bid on supported services may not simultaneously help the applicant evaluate submitted bids or select the winning bid.<sup>487</sup> In response to concerns raised by commenters that some health care providers are ignoring competing bids, we will also require applicants to respond to all service providers that have submitted questions or proposals during the procurement process.<sup>488</sup> We remind program participants that they also have an obligation to comply with any applicable state or local procurement laws, in addition to the Commission's competitive bidding requirements.<sup>489</sup>

162. Conversely, as in the past, we will find that it is a violation of the Commission's "fair and open" competitive bidding standard if: (1) a vendor, or any individual that has a financial or ownership interest in such a vendor, submits a bid and also prepares, signs, or submits the applicant's request for services;<sup>490</sup> (2) a vendor, or any individual that has a financial or ownership interest in such a vendor, submits a bid and also participates in the applicant's bid evaluation or vendor selection process in any way;<sup>491</sup> (3) the applicant has a relationship with a vendor that would unfairly influence the outcome of

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participating in the bidding process, the ability to hold a fair and open competitive bidding process is irreparably impaired).

<sup>481</sup> See 47 CFR § 54.642.

<sup>482</sup> See, e.g., ADTRAN Comments at 8; USTelecom Comments at 18-19; TeleQuality Comments at 24; KSLLC Comments at 15.

<sup>483</sup> See, e.g., ADTRAN Comments at 8; USTelecom Comments at 18-19; TeleQuality Comments at 24-25; KSLLC Comments at 15; KSLLC Reply Comments at 18; TeleQuality Reply Comments at 5-6.

<sup>484</sup> See 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules; 47 CFR § 54.642(b)(1).

<sup>485</sup> See 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules; see also SHLB Reply Comments at 7.

<sup>486</sup> See 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules.

<sup>487</sup> *Id.*

<sup>488</sup> *Id.*; see also TeleQuality Comments at 24-25; TeleQuality Reply Comments at 5-6; INCOMPAS Reply Comments at 7.

<sup>489</sup> See 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules.

<sup>490</sup> See, e.g., *Hospital Networks Order*, 31 FCC Rcd at 5739, para. 15 (finding a conflict of interest where one individual having ownership or leading positions with two entities represented each entity on both sides of a contractual transaction); *Request for Review by SEND Technologies, L.L.C. of the Decision of the Universal Service Administrator*, CC Docket Nos. 96-45, 97-21, Order, 22 FCC Rcd 4950 (2007) (finding that applicant's 15% ownership interest in service provider resulted in a conflict of interest that impeded fair and open competition).

<sup>491</sup> See, e.g., *Hospital Networks Order*, 31 FCC Rcd at 5740-41, paras. 17-18.

a competition or would furnish the vendor with “inside” information;<sup>492</sup> (4) the applicant’s RFP or request for services form does not describe the desired products and services with sufficient specificity to enable interested parties to submit responsive bids;<sup>493</sup> (5) a vendor representative is listed as the contact person on the applicant’s request for services and that vendor also participates in the competitive bidding process;<sup>494</sup> or (6) the applicant’s consultant is affiliated with the vendor selected to provide the requested services.<sup>495</sup> Although some of these clarifications of the “fair and open” standard have yet to be applied to the RHC Program, we believe that the RHC Program is equally at risk to the anti-competitive conduct that prompted the Commission to issue the clarifications in other Universal Service Fund contexts. We also emphasize that this is not an exhaustive list of the types of conduct that violate the Commission’s “fair and open” competitive bidding standard. Because we cannot anticipate and address every possible action that parties may take in the RHC Program application and competitive bidding process, we expect that we will continue to use the appeal process as necessary to address alleged competitive bidding violations.

#### **4. Extending the Healthcare Connect Fund Program Competitive Bidding Exemptions to the Telecom Program**

163. We align the Commission’s rules exempting certain applicants from the competitive bidding requirements in the Telecom and Healthcare Connect Fund Programs. Applicants qualifying for a competitive bidding exemption are not required to initiate a bidding process by preparing and posting a request for services form (i.e., an FCC Form 461 for the Healthcare Connect Fund Program and an FCC Form 465 for the Telecom Program). Instead, they may proceed directly to submitting a funding request by filing an FCC Form 462 for the Healthcare Connect Fund Program or an FCC Form 466 for the Telecom Program.

164. Under Healthcare Connect Fund Program rules, there are five exemptions to the competitive bidding process: (1) applications seeking support for \$10,000 or less of total undiscounted eligible expenses for a single year; (2) applicants who are purchasing services and/or equipment from master services agreements (MSAs) negotiated by federal, state, Tribal, or local government entities on behalf of such applicants; (3) applicants purchasing services and/or equipment from an MSA that was subject to the Healthcare Connect Fund and Pilot Programs competitive bidding requirements; (4) applicants seeking support under a contract that was deemed “evergreen” by the Administrator; and (5) applicants seeking support under an E-Rate contract that was competitively bid consistent with E-Rate

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<sup>492</sup> See, e.g., *Request for Review by Approach Learning and Assessment Center*, CC Docket No. 96-45, Order, 22 FCC Rcd 5296, 5303-04, para. 19 (WCB 2007) (*Approach Learning Order*) (finding that service provider participation may have suppressed fair and open competitive bidding).

<sup>493</sup> See, e.g., *Request for Review of the Decision of the Universal Service Administrator by Ysleta Independent School District*, CC Docket Nos. 96-45, 97-21, Order, 18 FCC Rcd 26407, 26419-20, paras. 27-28 (2003) (stating in the E-Rate context that a request for services listing virtually all eligible products and services violates the Commission’s competitive bidding requirements); see also TeleQuality Reply Comments at 5-6.

<sup>494</sup> See, e.g., *Mastermind Internet Services Order*, 16 FCC Rcd at 4032-33, para. 10 (finding that the FCC Form 470 contact person influences an applicant’s competitive bidding process by controlling the dissemination of information regarding the services requested and, when an applicant delegates that power to an entity that also participates in the bidding process as a prospective service provider, the applicant impairs its ability to hold a fair competitive bidding process); *Approach Learning Order*, 22 FCC Rcd at 5303-04, para. 19 (explaining that the contact person has great influence over the competitive bidding process and that process is impaired when the applicant delegates that authority to a party who also participates in the competitive bidding process) (internal citations omitted).

<sup>495</sup> See, e.g., *Hospital Networks Order*, 31 FCC Rcd at 5740-41, para. 18.



Program rules.<sup>496</sup> Only the “evergreen” contract exemption applies to applicants in the Telecom Program, although that exception is not codified in our rules.<sup>497</sup>

165. Commenters support our proposal in the *2017 Promoting Telehealth Notice and Order* to harmonize the Commission’s rules in both RHC Programs by codifying the following Healthcare Connect Fund Program competitive bidding exemptions in the Telecom Program: (1) applicants who are purchasing services and/or equipment from MSAs negotiated by federal, state, Tribal, or local government entities on behalf of such applicants; (2) applicants purchasing services and/or equipment from an MSA that was subject to the Healthcare Connect Fund and Pilot Programs competitive bidding requirements; (3) applicants seeking support under a contract that was deemed “evergreen” by the Administrator; and (4) applicants seeking support under an E-Rate contract that was competitively bid consistent with E-Rate Program rules.<sup>498</sup> As we have seen in the Healthcare Connect Fund Program, sufficient safeguards are already in place to protect against waste, fraud, and abuse in these situations because the contracts are the result of a competitive bidding process in which the most cost-effective service provider is identified and selected.<sup>499</sup> These exemptions also remove unnecessary and duplicative competitive bidding requirements while still ensuring fiscal responsibility, and better serve health care providers by improving and streamlining the application process.<sup>500</sup> Codifying these exemptions in the Telecom Program will likely yield the same benefits for Telecom Program applicants. We therefore revise the Commission’s competitive bidding rules accordingly.<sup>501</sup>

## 5. Adopting the E-Rate Program Gift Rule

166. We codify gift restrictions for the RHC Program that are similar to the gift rules applicable in the E-Rate Program.<sup>502</sup> Specifically, we adopt restrictions prohibiting an RHC Program applicant and/or its consultant, if applicable, from directly or indirectly soliciting or accepting a gift (i.e., anything of value, including meals, tickets to sporting events, or trips) from a service provider participating in or seeking to participate in the RHC Program.<sup>503</sup> As part of this rule, we also prohibit service providers participating in or seeking to participate in the RHC Program from offering or providing any such gifts, gratuity, favor, entertainment, loan, or any other thing of value to those personnel of

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<sup>496</sup> 47 CFR § 54.642(h).

<sup>497</sup> To be considered “evergreen,” the multi-year contract must meet the following criteria: (1) both parties are identified; (2) the health care provider has signed and dated the contract; (3) the contract specifies the type and terms of services; (4) the contract has a specified duration; (5) the contract specifies the cost of services to be provided; and (6) the contract includes the physical addresses or other identifying information of the health care providers purchasing from the contract. See USAC, *Evergreen Contracts*, <http://www.usac.org/rhc/telecommunications/health-care-providers/evergreen-contracts.aspx> (last visited July 2, 2019).

<sup>498</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10663-64, para. 101; see also KSLLC Comments at 16; TeleQuality Comments at 24. We decline, at this time, to adopt the \$10,000 or less exemption for the Telecom Program because it runs counter to our efforts to strengthen the competitive bidding process under the Telecom Program. Under the other exemptions, an initial competitive bidding process took place resulting in a contract approved for support.

<sup>499</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16787-93, paras. 250-65 (adopting the competitive bidding exceptions for the Healthcare Connect Fund).

<sup>500</sup> See, e.g., KSLLC Comments at 16; TeleQuality Comments at 24.

<sup>501</sup> See 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules.

<sup>502</sup> See 47 CFR § 54.503(d)(1)-(4) (E-Rate Program gift restrictions); *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10659-60, para. 89 (proposing to codify a gift rule that is similar to the E-Rate Program’s gift rule).

<sup>503</sup> See 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules.

eligible entities participating in the RHC Program.<sup>504</sup> The prohibition on offering or providing gifts includes any on-site product demonstration where the cost of the product, if purchased, licensed, or leased by the eligible entity's personnel for the length of time of the demonstration, would exceed the *de minimis* gift exception discussed below.

167. Like the E-Rate Program, the rules we adopt today allow two exceptions for *de minimis* gifts: (1) modest refreshments that are not offered as part of a meal (e.g., coffee and donuts provided at a meeting) and items with little intrinsic value solely for presentation (e.g., certificates and plaques); and (2) items that are worth \$20 or less, as long as those items do not exceed \$50 per employee from any one source per calendar year.<sup>505</sup> In determining the amount of gifts from any one source, we will consider the aggregate value of all gifts from any employees, officers, representatives, agents, independent contractors, or directors of the service provider in a given calendar year. These restrictions do not discourage companies from making charitable donations to RHC Program applicants, as long as such contributions are not directly or indirectly related to RHC Program procurement activities or decisions. If contributions have no relationship to the procurement of RHC Program-eligible services and are not given by service providers to circumvent any RHC Program rules, such contributions will not violate the prohibition against gift-giving. Similarly, gifts to family members and personal friends, when those gifts are made using personal funds of the donor (without reimbursement from an employer) and are not related to a business transaction or business relationship, will not violate our gift rules.

168. We emphasize that the restriction on gifts is always applicable and is not in effect or triggered only during the time period when competitive bidding is taking place.<sup>506</sup> In our experience, the solicitation, offering, or acceptance of improper gifts may take place outside of the competitive bidding period. Accordingly, we require an RHC Program applicant and/or its consultant, if applicable, to certify that it has not solicited or accepted a gift or any other thing of value from a service provider participating in or seeking to participate in the RHC Program.<sup>507</sup> We also require service providers to certify that they have not offered or provided a gift or any other thing of value to the applicant (or to the applicant's personnel, including its consultant) for which it will provide services.<sup>508</sup> To assist service providers to more easily identify those entities that are covered by the gift restrictions, we recommend that service providers routinely search the Open Data platform maintained by the Administrator listing the entities participating in the RHC Program, as well as the locations receiving RHC Program support.<sup>509</sup>

169. The gift rules we codify today offer a fair balance between prohibiting gifts that may have undue or improper influence on a procurement decision and acknowledging the realities of professional interactions, which may occasionally involve giving people modest refreshments or a token gift. We agree with commenters who argue that these rules are appropriate for ease of administration and provide clarity for applicants and service providers.<sup>510</sup> We also concur that they are a necessary step to eliminate fraud and abuse in the RHC Program.<sup>511</sup> We remind applicants and service providers that they

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<sup>504</sup> *Id.*

<sup>505</sup> Compare E-Rate Program's gift restrictions with 47 CFR § 54.622, as adopted herein; Appx. A, Final Rules.

<sup>506</sup> See, e.g., KSLLC Comments at 14; KSLLC Reply Comments at 16.

<sup>507</sup> *Id.*

<sup>508</sup> *Id.*

<sup>509</sup> See, e.g., AT&T Reply Comments at 14; USTelecom Comments at 19-20.

<sup>510</sup> See, e.g., NSHC Comments at 9; CATG Comments at 2; ANTHC Comments at 2; BBAHC Comments at 11; Maniilaq Comments at 7; NACHC Comments at 20; ADTRAN Comments at 7; ANHB Comments at 8; USTelecom Comments at 19; SHLB Comments at 34, TeleQuality Comments at 24; KSLLC NPRM Comments at 14; KSLLC Reply Comments at 16; ADS Comments at 4; ADS Reply Comments at 2.

<sup>511</sup> See, e.g., AT&T Reply Comments at 12-13.

remain subject to applicable state and local gift restrictions. To the extent a state or local provision is more stringent than the federal requirements, violation of the state or local provision constitutes a violation of the Commission's rules adopted herein. Our new rules applicable to gifts will become effective for funding year 2020.

## 6. Implementing Rules Governing Consultants

170. The RHC Program permits applicants to use a consultant or other third party to file FCC Forms and supporting documentation on their behalf. In this Report and Order, we harmonize across both programs requirements regarding the use of consultants as well as adopt other specific requirements to ensure the integrity of the competitive bidding process and to prevent incidents of waste, fraud, and abuse. Specifically, we require applicants to submit a declaration of assistance with their request for services identifying each and every consultant, vendor, or other outside expert, whether paid or unpaid, who aided in the preparation of their applications and, as part of this declaration, to describe the nature of their relationship with the consultant, vendor, or other outside expert providing the assistance.<sup>512</sup> We also require participating service providers (in each RHC Program) to disclose, on the appropriate RHC Program form, the names of any consultants or third parties who helped them identify the applicant's RFP or otherwise helped them to connect with the health care provider participating in the RHC Program.<sup>513</sup> Applicants and service providers must certify, on the appropriate RHC Program form, that the consultants or other third parties they hire do not have an ownership interest, sales commission arrangement, or other financial stake in the vendor chosen to provide the requested services, and that they have otherwise complied with RHC Program rules, including the Commission's rules requiring fair and open competitive bidding.<sup>514</sup> We emphasize that applicants and service providers are accountable for the actions of their consultants or outside experts should we find that those consultants or experts have engaged in conduct that undermines fair and open competitive bidding.<sup>515</sup> Our new rules governing consultants and other third parties will become effective for funding year 2020.

171. To enable the Administrator and the Commission to identify individuals providing consultant services in the RHC Program, we direct the Administrator to establish a consultant registration process that is similar to the process in place for the E-Rate Program.<sup>516</sup> We agree with commenters who argue that requiring unique registration numbers for consultants or outside experts is a simple and effective way of identifying those individuals and the firms that employ them.<sup>517</sup> Under this registration process, an individual who has been identified as the applicant's consultant or other outside expert must provide to the Administrator his or her name and contact information, the name and contact information of the consulting firm or company that employs him or her, and a brief description of the role he or she

<sup>512</sup> See 47 CFR §§ 54.622, as adopted herein; Appx. A, Final Rules; *see also* NRHA Comments at 3.

<sup>513</sup> See, e.g., KSLLC Comments at 13-14.

<sup>514</sup> See, e.g., NCTA Comments at 6; TeleQuality Comments at 25.

<sup>515</sup> For example, consultants or outside experts who have an ownership interest, sales commission arrangement, or other financial stake with respect to a bidding service provider may not: (1) prepare, sign, or submit the FCC Form 461 or FCC Form 465 or supporting documentation on the applicant's behalf; (2) serve as consortium leaders or another point of contact on behalf of the applicant; (3) prepare or assist in the development of the applicant's competitive bidding evaluation criteria; or (4) participate in the bid evaluation or service provider selection process. Note that this is not an exhaustive list of the types of actions that undermine the competitive bidding process.

<sup>516</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10659, para. 87 (seeking comment on whether to require the consultant or outside expert to obtain a unique consultant registration number from the Administrator as is the current practice in the E-Rate Program); USAC, *Consultant Registration Numbers*, <http://www.usac.org/sl/applicants/step01/consultant-registration-numbers.aspx> (last visited July 2, 2019) (providing the process for obtaining a consultant registration number in the E-Rate Program) (E-Rate Consultant Registration Process); *see also* KSLLC Comments at 12-13; KSLLC Reply Comments at 16.

<sup>517</sup> See, e.g., ADS Comments at 4; KSLLC Comments at 13.

will undertake in assisting the applicant.<sup>518</sup> Once this information is provided, the Administrator will then issue a unique registration number to the consultant or outside expert and that number will be linked to the applicant's organization. These measures provide transparency for RHC Program participants regarding the roles and limitations of their consultants, while at the same time, facilitate the ability of the Administrator, the Commission, and law enforcement officials to identify and hold accountable those individuals who engage in illegal acts<sup>519</sup> or otherwise damage the integrity of an applicant's competitive bidding process.<sup>520</sup>

#### **E. Improving RHC Program Administration**

172. In this section, we adopt a number of measures to ease administrative burdens on applicants and establish consistency between the RHC Programs. To the extent possible, the measures we adopt today are similar to those adopted for the E-Rate Program in order to establish consistency in the administration of the Universal Service Fund programs. We believe these actions will provide applicants with greater certainty throughout the application process and facilitate smoother and swifter funding decisions.

##### **1. Providing Additional Time for Competitive Bidding Process**

173. We revise the RHC Program procedures, effective funding year 2021, to give applicants additional time to conduct their competitive bidding process prior to the start of the funding year rather than the current six months. To receive RHC Program support, an applicant must first conduct a competitive bidding process for eligible services by submitting an FCC Form 465 (Telecom Program) or FCC Form 461 (Healthcare Connect Fund Program) to the Administrator for posting on its website.<sup>521</sup> Applicants must then wait at least 28 days before reviewing bids submitted in response to the postings and entering into a service agreement with the selected service provider.<sup>522</sup> Once an applicant has selected a provider and entered into a service contract, the applicant can then submit its request for discounts to the Administrator by filing an application for support, either an FCC Form 466 (Telecom Program) or an FCC Form 462 (Healthcare Connect Fund Program).<sup>523</sup>

174. Pursuant to current RHC Program procedures, applicants are permitted to start the competitive bidding process no earlier than January 1, six months prior to the start of the applicable funding year.<sup>524</sup> This six-month period gives applicants very limited time within which to conduct

<sup>518</sup> See, e.g., E-Rate Consultant Registration Process.

<sup>519</sup> See, e.g., *DataConnex NAL*, Notice of Apparent Liability for Forfeiture and Order, 33 FCC Rcd 1575 (2018) (finding that DataConnex apparently willfully and repeatedly engaged in conduct which undermined the competitive bidding process, and relied on apparently forged, false, misleading, and unsubstantiated documents to support its claims for payment from the Universal Service Fund); *Network Services Solutions NAL*, Notice of Apparent Liability for Forfeiture and Order, 31 FCC Rcd 12238 (2016) (finding that Network Services Solutions apparently willfully and repeatedly engaged in conduct which resulted in competitive bidding that was not fair and open, inflated the rates for services it charged to health care providers and the Universal Service Fund, and relied on apparently forged and false documents to support its claims for payment from the Universal Service Fund).

<sup>520</sup> See, e.g., *Hospital Networks Order*, 31 FCC Rcd at 5740-41, paras. 18-19.

<sup>521</sup> 47 CFR §§ 54.603, 54.642. See USAC, *Healthcare Connect Fund, Forms*, <https://www.usac.org/rhc/healthcare-connect/tools/forms/default.aspx> (last visited July 2, 2019) (Healthcare Connect Fund Program Forms); USAC, *Telecommunications Program, Forms*, <https://www.usac.org/rhc/telecommunications/tools/forms/default.aspx> (last visited July 2, 2019) (Telecom Program Forms).

<sup>522</sup> 47 CFR §§ 54.603(b)(3), 54.642(g).

<sup>523</sup> See Healthcare Connect Fund Program Forms; Telecom Program Forms.

<sup>524</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16784, para. 242; USAC, *Rural Health Care Program, Telecommunications Program, Program Calendar, FY2019 Recommended Form Submission Dates*, [https://www.usac.org/\\_res/documents/rhc/pdf/handouts/Recommended-Form-Submission-Dates-FY2019.pdf](https://www.usac.org/_res/documents/rhc/pdf/handouts/Recommended-Form-Submission-Dates-FY2019.pdf) (last visited July 2, 2019) (continued....)

competitive bidding prior to the opening of the application filing window for a given funding year. For example, for funding years 2018 and 2019, the application filing window opened on February 1, giving applicants, in practice, only one month to conduct a competitive bidding process prior to the start of the application filing window.<sup>525</sup> While January 1 provides six months prior to the start of the funding year for competitive bidding, in practice, applicants need to complete bidding prior to the start of the application filing window, which opens months prior to the start of the funding year.

175. We now recognize that this time period is insufficient for applicants to thoroughly conduct competitive bidding and select a service provider prior to submitting an application for RHC Program support. We agree with commenters that applicants merit additional time prior to the opening of the application filing window to submit their request for services along with a request for proposal, if necessary, so they can more thoroughly review bids received and complete contracts with a service provider prior to the application filing window.<sup>526</sup> We thus provide applicants with additional time beyond the current six months to initiate the competitive bidding process prior to the start of the funding year. Specifically, beginning in funding year 2021, applicants can initiate their competitive bidding processes as early as July 1 of the prior year.<sup>527</sup> This will give applicants more time to complete the bidding process and finalize contracts prior to filing their applications. This timeframe is also consistent with the E-Rate Program in which applicants generally have one year before the start of the funding year.<sup>528</sup> Additionally, it will help to ensure that applicants' requests for services are more detailed and better targeted to meet their telehealth needs.<sup>529</sup>

## 2. Establishing an Application Filing Window

176. We revise our rules to require the Administrator to open an initial application filing window with an end date no later than 90 days prior to the start of the funding year (i.e., no later than April 1).<sup>530</sup> Similar to the E-Rate Program, where the application filing window closes in advance of the funding year, these revisions will give the Administrator time to begin processing submitted RHC Program applications prior to the start of the funding year and, therefore, expedite the issuance of funding decisions. It will also provide more certainty to applicants by establishing an end date by which applications must be filed<sup>531</sup> and provide sufficient time for the Administrator to publish a gross demand estimate prior to the start of the funding year.<sup>532</sup> The Administrator will continue to treat all eligible

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visited July 2, 2019). Funding years run from July 1 through June 30 of the following calendar year (e.g., funding year 2020 starts on July 1, 2020 and ends on June 30, 2021).

<sup>525</sup> See USAC, *Rural Health Care Program, FY2019 Filing Window Period*, <https://www.usac.org/rhc/tools/program-calendar.aspx?pgm=hcc> (last visited July 2, 2019); USAC, *Newsletter for February 2018* (Feb. 1, 2018), <https://www.usac.org/rhc/tools/news/news-archive.aspx?pgm=hcc>.

<sup>526</sup> See, e.g., TeleQuality Comments at 23; SHLB Comments 30-31; Franciscan Alliance & Parkview Health Comments at 17-19; ACS Comments at 41-42; KSLLC Reply Comments at 19; USTelecom Comments at 21.

<sup>527</sup> For example, for funding year 2021, which begins on July 1, 2021, applicants can start the competitive bidding process on July 1, 2020. Because the final rules will not become effective until after July 1, 2019, we are unable to provide a full year for competitive bidding for funding year 2020.

<sup>528</sup> See USAC, *Competitive Bidding*, <https://www.usac.org/sl/applicants/step01/default.aspx> (last visited July 2, 2019).

<sup>529</sup> See Part III.D.1 (requiring more detailed information as part of the competitive bidding process under the RHC Program).

<sup>530</sup> See 47 CFR § 54.626, as amended herein; Appx. A, Final Rules.

<sup>531</sup> *Id.*

<sup>532</sup> We direct the Administrator to publicly file in the Commission's docket for the RHC Program a gross demand estimate for each funding year. We direct the Administrator to file this gross demand estimate 30 days prior to the start of the pertinent funding year. We recognize that the gross demand figures provided will be based on the data (continued....)



health care providers filing within this initial window period as if their applications were simultaneously received.<sup>533</sup> All funding requests submitted outside of a filing window will not be accepted unless and until the Administrator opens another filing window.<sup>534</sup> Prior to announcing the initial opening and closing dates of the application filing window each year, the Administrator shall seek approval of the proposed dates from the Chief of the Wireline Competition Bureau.<sup>535</sup> This change will become effective for funding year 2021 to coincide with our change to the start date of the competitive bidding process for the RHC Program.

177. Commenters generally request a set application filing window period (i.e., with start and end dates that remain static from year-to-year) so that they can plan their program participation accordingly,<sup>536</sup> and suggest that the Administrator issue decisions on all funding requests filed within the application filing window on a rolling basis (even if exact dollar amounts need to await the results of pro rata calculations).<sup>537</sup> We recognize the value in establishing a set application filing window for applicants for planning purposes, given the potential for unforeseeable events and variables; we also seek, however, to ensure that the Administrator is prepared to open the application filing window (i.e., adequate staffing resources, information technology system is fully operational) prior to announcing it for a given funding year. We believe that requiring the Administrator to establish an initial application filing window end date sufficiently far in advance of the start of the funding year provides applicants with a more predictable timeframe as they prepare their competitive bidding processes and applications. It also provides flexibility to the Administrator to take any steps necessary to prepare for the application filing window. Given that we are providing applicants with a full year to conduct their competitive process and finalize contracts with their service providers prior to the start of the funding year, they should be in a better position to submit their funding requests upon the opening of the application filing window period.

178. We also believe that establishing an initial application filing window that treats all eligible health care providers filing within the window as if their applications were simultaneously received rather than issuing funding requests on a rolling basis, as some commenters suggest,<sup>538</sup> provides more certainty to the application and funding commitment process. Specifically, by establishing a filing window period, we provide a mechanism for the Administrator to more efficiently administer the RHC Program and process requests while providing an incentive for applicants to timely submit their applications for support. The Administrator will immediately begin reviewing applications submitted

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available to the Administrator at the close of the application filing windows(s) and that actual demand cannot be ascertained until the Administrator completes a review of the funding requests to identify filing errors that have significantly lowered demand estimates in the past (e.g., typographical errors, duplicate filings). We appreciate, however, that program participants are interested in having a general understanding of where demand stands at the close of the filing application window(s) and direct the Administrator to provide that information. We direct the Wireline Competition Bureau to specify the content requirements of the gross demand estimate filed by the Administrator. We also direct the Wireline Competition Bureau to require a demand estimate to be filed at a different time or based on a different standard if warranted by new circumstances impacting program administration (e.g., the Administrator implements a new system allowing it to produce a net demand estimate in a shorter time).

<sup>533</sup> 47 CFR § 54.675(c)(2).

<sup>534</sup> See 47 CFR § 54.626, as amended herein; Appx. A, Final Rules.

<sup>535</sup> *Id.*

<sup>536</sup> See, e.g., USTelecom Comments at 21; Franciscan Alliance & Parkview Health Comments at 17-19; KSLLC Comments at 17.

<sup>537</sup> See, e.g., NETC Comments 6-7; ACS Reply Comments at 43-44; USTelecom Comments at 21; SHLB Comments at 31-32; KSLLC Comments at 17.

<sup>538</sup> See *id.*

within the initial application filing window and will not wait until the close of the application filing window to begin its review.

179. If requests submitted during an established application filing window period exceed the RHC Program's cap, per the rules we adopt today, the Administrator shall prioritize support based on the prioritization categories until all available RHC Program funding is committed.<sup>539</sup> If funding requests submitted during the initial application filing window do not exceed the cap, the Administrator will determine, based on demand and available funding, and after consultation with Commission staff, whether to open additional application filing window periods and the duration of any such application filing window periods.<sup>540</sup> To the extent the Administrator opens an additional application filing window period, it shall continue to provide notice and include either in that notice, or soon thereafter, the amount of remaining available funding.<sup>541</sup> We believe that these changes to the application filing window period will provide applicants with more certainty regarding the initial application filing window, thus making it easier for applicants to plan accordingly, and will allow the Administrator to start making commitments prior to the start of the funding year.<sup>542</sup>

### **3. Expanding the Administrator's Authorization to Extend Service Delivery Deadline**

180. Health care providers are required to use the services for which support has been committed by the Administrator within the funding year for which the support was sought.<sup>543</sup> Consistent with this requirement, the Administrator has routinely issued funding commitments to RHC Program applicants for recurring and non-recurring eligible services with a funding end date no later than June 30.<sup>544</sup> The Commission has acknowledged that external circumstances beyond a health care provider's

<sup>539</sup> See 47 CFR § 54.621(b), as adopted herein; Appx. A, Final Rules. The Commission's prioritization rules are discussed in more detail in Parts III.B.1-3.

<sup>540</sup> See 47 CFR § 54.621(a)(2), as adopted herein; Appx. A, Final Rules.

<sup>541</sup> See *Wireline Competition Bureau Provides a Filing Window Period Schedule for Funding Requests Under the Telecommunications Program and the Healthcare Connect Fund*, WC Docket No. 02-60, Public Notice, 31 FCC Rcd 9588, 9591-92 (WCB 2016); 47 CFR § 54.621(a)(2), as adopted herein; Appx. A, Final Rules.

<sup>542</sup> Also, we note that applicants also have an important role in expediting the application review process by ensuring that their applications are submitted with all supporting documentation during the application filing window. See *FCC Form 466 Documentation Order*, 30 FCC Rcd at 231, para. 3 (finding that allowing applicants to submit supporting documentation after the funding year or inadequate supporting documentation compromises the efficiency and effectiveness of the RHC Program).

<sup>543</sup> For example, if an applicant seeks support for funding year 2020, only those charges incurred in funding year 2020 are eligible for support. Similarly, if an applicant seeks support for funding years 2020 and 2021 under the Healthcare Connect Fund Program, only those charges incurred during funding years 2020 and 2021 are eligible for support. See *Universal Service First Report and Order*, 12 FCC Rcd at 9144, para. 714; *Healthcare Connect Fund Order*, 27 FCC Rcd at 16818, para. 352 and 16795, para. 273 (indicating that an applicant can submit a request for funding at any time during the funding year for services received during that funding year) and (stating that "[an] applicant may request support for services provided at any time during the funding year after it signs a valid contract (or otherwise enters into a service agreement) with its selected provider."); 47 CFR § 54.675(e) (requiring that the Administrator shall only commit funds to cover the portion of a long-term contract that is scheduled to be delivered during the funding year for which the support is sought); 47 CFR § 54.675(b) (providing that a funding year extends from July 1 through June 30 of the subsequent year); 47 CFR § 54.675(d) (requiring health care providers to file new funding requests for each funding year); 47 CFR § 54.634(b)(1) (creating an exception to the requirement that services must be provided within the funding year for which support is sought for non-recurring charges for dark fiber).

<sup>544</sup> There have been instances in which the Administrator has issued a funding commitment letter with a funding end date prior to June 30 to coincide with a contract end date. See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16802, para. 297 (stating that a "a multi-year funding commitment cannot extend beyond the end of the contract

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control can create situations where implementing non-recurring services by the end of the applicable funding year is impractical. Such circumstances include, but are not limited to, natural disasters and extreme weather events (e.g., hurricanes), orders from state or municipal governments to halt deployments due to unforeseeable events, delayed funding decisions by the Administrator that preclude completing a project by the service delivery deadline, and an unforeseeable failure by a third party to deliver equipment or facilities necessary to complete a service.<sup>545</sup> Further, we realize that many applicants understandably are hesitant to install services or begin construction before receipt of a funding commitment letter, particularly in instances where there is a significant financial obligation required. We also recognize that implementing non-recurring services, such as service installation, infrastructure and network construction, are significant undertakings, both in time and cost.<sup>546</sup> If the Administrator does not issue funding commitments for a given funding year until the final quarter of that funding year, this then leaves insufficient time for applicants to complete their projects by the end of the applicable funding year. For those applicants where the Administrator has issued a funding commitment letter with a funding end date prior to June 30 to coincide with a contract end date, this further shortens the period of time an applicant that waits until the issuance of a funding commitment letter has to install services or complete a construction project to receive RHC Program support for eligible services. In these instances, applicants are precluded from maximizing the value of their funding commitments to cover the cost of eligible services for a given funding year.

181. Unlike the E-Rate Program, there is no mechanism in the RHC Program to seek an extension of the non-recurring service delivery deadline from the Administrator, except in the limited context of dark fiber.<sup>547</sup> An RHC Program applicant's only recourse, in instances where they are unable to meet the service delivery deadline, is to seek a waiver of the service delivery deadline from the

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submitted with the request for funding. For example, if an applicant submits a two-year contract and requests a multi-year funding commitment, the Administrator will only issue a funding commitment for two years. Similarly, if a contract ends in the middle of the funding year, the funding commitment can only extend to the end date of the contract.”).

<sup>545</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16738, para. 129; *Requests for Waiver by Grants/Cibola County School District, et al.*, CC Docket No. 02-6, Order, 33 FCC Rcd 10048 (WCB 2018) (granting waivers of the special construction deadline where the consortium's construction was halted by the state's transportation office prior to the completion date in order for an unforeseen archeological survey to be completed, and where the school district's service provider was unwilling to continue work on the project given the uncertainty around the project's funding while the Administrator completed its program compliance review); *Requests for Review/Waiver of the Decision of the Universal Service Administrator by Accelerated Charter*, CC Docket No. 02-6, Order, 29 FCC Rcd 13652, 13652-53, para. 2 (WCB 2014) (granting waivers of the service delivery deadline for non-recurring services where the petitioners timely filed their FCC Forms 500 indicating that their contract dates were being extended beyond the service delivery deadline but failed to also promptly file a written request to extend the service delivery deadline); *Request for Review of the Decision of the Universal Service Administrator by Houston Independent School District*, CC Docket No. 02-6, Order, 20 FCC Rcd 16775, 16777-78, para. 6 (WCB 2005) (granting a waiver of the service delivery deadline for non-recurring services when funding disbursements were delayed while the Administrator conducted further review of the application for program compliance).

<sup>546</sup> Unlike non-recurring services, recurring services are implemented throughout the funding year and do not require as much time and labor to implement as non-recurring expenses.

<sup>547</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16738, para. 129 (Only applicants seeking support for non-recurring charges for dark fiber under the Healthcare Connect Fund Program may request up to a one-year extension of the June 30 deadline to light the fiber if they provide documentation to the Administrator that construction was unavoidably delayed due to weather or other reasons.); 47 CFR § 54.634(b)(1). This extension, however, was not also expressly created for leased lit fiber or self-provisioned networks. See 47 CFR § 54.634(b)(1); *Healthcare Connect Fund Order*, 27 FCC Rcd at 16738, para. 129.

Commission.<sup>548</sup> Until the Commission addresses the waiver request, an applicant is uncertain whether any charges incurred after the end of the non-recurring service delivery deadline will be granted.

182. To mitigate such uncertainty and reduce administrative burdens, we take two actions to simplify the administration and resolution of service delivery deadline issues in the RHC Program. First, we eliminate funding request-specific service delivery deadlines based on individual contract end dates, and establish June 30 of the funding year for which the program support was sought as the service delivery deadline for all services in the RHC Program.<sup>549</sup> This creates a single implementation deadline for the RHC Program that is easy for the Administrator to track and allows applicants to pursue options for maximizing their approved funding commitments up to the end of the funding year should circumstances beyond their control prevent delivery by an earlier contract date. Applicants will still be required to submit their service contracts to the Administrator with their funding requests, and the support amount approved must be limited to charges incurred during the contract's term. Stated differently, by establishing a universal June 30 service delivery deadline, we do not make additional funding available to applicants beyond their contract terms.<sup>550</sup> Thus, applicants whose contract term ends prior to June 30 must obtain a contract extension and notify the Administrator of such extension in order to receive funding through the June 30 service delivery deadline.

183. Second, we adopt, with a few modifications, the E-Rate Program's rule authorizing the Administrator to grant a one-year extension of the service delivery deadline for non-recurring services.<sup>551</sup> Specifically, effective funding year 2020, RHC Program applicants meeting the following criteria will qualify for a one-year extension of the service delivery deadline for non-recurring services:<sup>552</sup> (1) applicants whose funding commitment letters are issued by the Administrator on or after March 1 of the funding year for which discounts are authorized; (2) applicants that receive service provider change authorizations or site and service substitution authorizations from the Administrator on or after March 1 of the funding year for which discounts are authorized;<sup>553</sup> (3) applicants whose service providers are unable to complete implementation for reasons beyond the service provider's control;<sup>554</sup> or (4) applicants whose service providers are unwilling to complete delivery and installation because the applicant's funding request is under review by the Administrator for program compliance.<sup>555</sup> The Administrator shall automatically extend the service delivery deadline in situations where criteria (1) or (2) are met. Applicants, however, must affirmatively request an extension on or before the June 30 deadline for

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<sup>548</sup> See 47 CFR 54.719(c).

<sup>549</sup> See 47 CFR § 54.626, as adopted herein; Appx. A, Final Rules.

<sup>550</sup> For instance, if a health care provider enters into a service contract with a term of July 1, 2020 to April 30, 2021, the Administrator may only issue a funding commitment for charges incurred pursuant to the contract between July 1, 2020 and April 30, 2021 absent a contract extension.

<sup>551</sup> See 47 CFR § 54.626, as adopted herein; Appx. A, Final Rules. The Administrator will calculate a revised service delivery deadline based on the date that the applicant satisfies one of the conditions and will then issue a revised funding commitment letter. This one-year extension will not apply to applicants in the Healthcare Connect Fund Program that receive multi-year funding commitments which can cover a period of up to three funding years. Unlike a single year commitment, a multi-year commitment provides applicants with ample time to complete installation of service in addition to allowing for any changes within the scope of the contract, as necessary.

<sup>552</sup> We note that granting an extension does not increase the amount of support, rather it merely provides applicants with additional time in which to install services or complete their construction projects.

<sup>553</sup> See Part III.E.5 (discussing the procedures for requesting Service Provider Identification Number (SPIN) changes and site and service substitutions).

<sup>554</sup> This includes those requests for an extension to light fiber where construction was unavoidably delayed due to weather or other reasons. 47 CFR 54.634(b)(1).

<sup>555</sup> See 47 CFR § 54.626, as adopted herein; Appx. A, Final Rules.

criteria (3) and (4). We direct the Administrator to create a mechanism for health care providers to submit such extension requests. We also direct the Administrator to issue its decisions on service delivery deadline requests within two months.

184. March 1 is the key date for determining whether to extend the deadline based on criteria (1) or (2). If one of the conditions is satisfied before March 1 (of any year), the deadline will not be extended, and the applicant will have until June 30 of that calendar year to complete implementation. If one of the conditions is satisfied on or after March 1, the applicant will have until June 30 of the following calendar year to complete implementation.<sup>556</sup> We find that applicants who satisfy the conditions prior to March 1 have sufficient time before the end of the funding year to install services or complete their construction projects.

185. With regard to criterion (3)—applicants whose service providers are unable to complete implementation for reasons beyond the service provider’s control—we recognize that there may be a wide range of situations in which an applicant, through no fault of its own, is unable to complete installation by June 30.<sup>557</sup> Because we are unable to anticipate every type of circumstance that may arise, we direct the Administrator to address such situations on a case-by-case basis. Applicants must submit documentation to the Administrator requesting relief on these grounds on or before June 30 of the relevant funding year. That documentation must include, at a minimum, an explanation regarding the circumstances that make it impossible for installation to be completed by June 30 and a certification by the applicant that, to the best of its knowledge, the request is truthful.

186. Finally, with regard to criterion (4)—applicants whose service providers are unwilling to complete delivery and installation because the applicant’s funding request is under review by the Administrator for program compliance—applicants must certify to the Administrator that their service provider was unwilling to deliver or install the non-recurring services before the end of the funding year. Applicants must make this certification on or before June 30 of the relevant funding year. The revised implementation date will be calculated based on the date the Administrator issues a funding commitment.<sup>558</sup> For example, if the Administrator delays funding for funding year 2020 while reviewing an applicant’s funding request for program compliance, the applicant will need to file a certification with the Administrator by June 30, 2021.

187. We find that this one-year extension for all non-recurring services, including the existing one-year extension available for dark fiber,<sup>559</sup> provides an appropriate timeframe within which to install services or complete construction, and is consistent with the Commission’s existing extensions for non-recurring services and special construction under the E-Rate Program in order for the services to be eligible for support.<sup>560</sup> Additionally, implementation of this policy will provide clarity to the Administrator and applicants by establishing a certain deadline for installation of services.<sup>561</sup>

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<sup>556</sup> Thus, if an applicant receives its funding year 2020 funding commitment letter, a service provider change authorization, or a site and service substitution authorization on February 20, 2021 (before March 1), the deadline for the delivery of non-recurring services will be June 30, 2021. By contrast, for funding commitments made in April 2021 for funding year 2020 (after March 1), the deadline for delivery of non-recurring services will be June 30, 2022.

<sup>557</sup> See *supra* note 547.

<sup>558</sup> Thus, if the Administrator issues the funding commitment before March 1, 2022, the applicant will have until June 30, 2022 to complete installation. If the Administrator makes the funding commitment on or after March 1, 2022, the applicant will have until June 30, 2023 to complete installation.

<sup>559</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16738, para. 129; 47 CFR § 54.634(b)(1) (creating an exception to the requirement that services must be provided within the funding year for which support is sought for non-recurring charges for dark fiber due to unavoidable construction delays).

<sup>560</sup> See 47 CFR §54.507(d)(4) (E-Rate Program extension for non-recurring services); *Modernizing the E-Rate Program for Schools and Libraries, Connect America Fund*, WC Docket Nos. 13-184, 10-90, Second Report and (continued....)



#### 4. Improving the Invoicing Process

188. *Establishing a Uniform Invoicing Deadline.* To alleviate inefficiencies with respect to the Telecom Program funding disbursement process and harmonize the filing deadlines for the Telecom and Healthcare Connect Fund Programs, we establish a uniform invoice filing deadline for the RHC Program beginning with funding year 2020. The rule we adopt today requires all invoices under the RHC Program to be submitted to the Administrator within four months (120 days) after the later of: (1) the service delivery deadline; or (2) the date of a revised funding commitment letter issued pursuant to an approved post-commitment request made by the applicant or service provider or a successful appeal of a previously denied or reduced funding request.<sup>562</sup> For example, for funding year 2020 funding commitments ending on June 30, 2021, the invoice deadline for submitting the invoice forms by the applicant to the Administrator, after approval by the service provider, is October 31, 2021. If the service delivery deadline is extended until June 30, 2022, then the invoice deadline would be October 31, 2022.<sup>563</sup> Similarly, if the Administrator approves a post-commitment request for funding year 2020 (e.g., a SPIN change request to change service providers or correct a service provider's identification number or a service substitution)<sup>564</sup> and the Administrator issues a revised funding commitment letter dated December 31, 2021, the invoice deadline would be April 30, 2022.<sup>565</sup>

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Order and Order on Reconsideration, 29 FCC Rcd 15538, 15558, para. 49 (2014) (*2014 Second E-Rate Order*) (E-Rate Program extension for dark fiber).

<sup>561</sup> We are aware that the Wireline Competition Bureau has before it a petition for waiver filed by NETC and Connections Telehealth Consortium (CTC), and inquiries by other entities seeking extensions of time to allow them to fully expend their RHC Program funding commitments for funding year 2017. *See* Petition for Waiver to Allow Rural Health Care Program Funding Commitments to be Fully Expended of NETC and CTC, CC Docket No. 02-60 (filed June 10, 2018); Email from Michael Batt, Hall, Render, Killian, Heath & Lyman, P.C., to Regina Brown, Telecommunications Access Policy Division, WCB (Apr. 6, 2018, 11:54a.m. EDT); Email from Boni Carrell, The Rural Nebraska Healthcare Network, to Regina Brown, Telecommunications Access Policy Division, WCB (Apr. 30, 2018, 11:29a.m. EDT); Email from Liane Steffes, Parr Richey Frandsen Patterson Kruse LLP, to Regina Brown, Telecommunications Access Policy Division, WCB (Apr. 30, 2018, 10:11a.m. EDT); Email from Katori Copeland, Davis Wright Tremaine LLP, to Regina Brown, Telecommunications Access Policy Division, WCB (May 15, 2018, 9:35a.m. EDT). We do not address this petition and other inquiries here because they involve circumstances specifically related to funding year 2017. The Wireline Competition Bureau will address this petition and other inquiries related to funding year 2017 separately in a subsequent order.

<sup>562</sup> *See* 47 CFR § 54.627(a), as adopted herein; Appx. A, Final Rules. Under the Telecom Program, service providers may file an invoice once they have received an approval of the FCC Form 467 (Connection Certification Form), Health Care Provider Support Schedule (HSS), and credited the health care provider's account. Under the Healthcare Connect Fund Program, once the health care provider has received a bill from the service provider and paid the 35% minimum contribution, it can create an invoice for the services received (using an FCC Form 463). Applicants appealing partially approved funding requests should submit invoices for the partial funding before the original invoice deadline because the Administrator will be unable to provide additional time to invoice if the post-commitment request is denied.

<sup>563</sup> The Commission's service delivery rules are discussed in more detail in Part III.E.3.

<sup>564</sup> *See* Part III.E.5 (discussing SPIN changes and site and service substitution requests).

<sup>565</sup> Consortia in the Healthcare Connect Fund Program requesting support for upfront payments that exceed, on average, \$50,000 per eligible site are required to prorate the requested support over at least three years. 47 CFR § 54.638(c)(1). The upfront payments must be part of a multi-year contract, 47 CFR § 54.638(c)(1), but not necessarily a multi-year commitment. For these single-year upfront payment requests, the service delivery deadline will be June 30 of the funding year for which the request was filed and the invoicing deadline will be three years from that service delivery deadline.

189. Commenters support the harmonization of the invoice deadline for the RHC Programs,<sup>566</sup> although there is some variance about what the deadline should be. For example, ACS supports a 180-day invoice deadline,<sup>567</sup> while USF Consultants state that the deadline should be 12 months after the end of the funding year.<sup>568</sup> We recognize that a deadline of 120 days reduces the current invoice deadline under the Healthcare Connect Fund Program for applicants by 60 days,<sup>569</sup> but we believe that 120 days coupled with the one-time 120-day invoice deadline extension we adopt below,<sup>570</sup> will provide applicants with sufficient time to submit their invoices and seek reimbursement from the Administrator. As the Commission has explained, filing deadlines are necessary for the efficient administration of the RHC Program.<sup>571</sup> The Commission previously found in the E-Rate context that a uniform 120-day invoice deadline provides the right balance between the need for efficient administration of the program and the need to ensure applicants and service providers have sufficient time to finish their own invoicing processes.<sup>572</sup> Establishing a uniform invoicing deadline will also provide certainty to applicants and service providers. Providing certainty on invoicing deadlines will allow the Administrator to de-obligate committed funds immediately after the invoicing deadline has passed, providing increased certainty about how much funding is available to be carried forward in future funding years.<sup>573</sup> This approach will result in a more efficient and effective administration of the RHC Program's disbursement process as well as providing applicants with faster funding timetables. We emphasize, however, that it is incumbent on the applicant and the service provider in each RHC Program to complete and timely submit their invoices to the Administrator or to timely seek an extension of the invoice deadline.<sup>574</sup>

190. *Establishing a One-Time Invoice Deadline Extension.* We also adopt a rule allowing service providers and billed entities to request and automatically receive a single one-time 120-day extension of the invoice deadline as is done in the E-Rate Program.<sup>575</sup> The invoice deadline extension rule will be effective beginning in funding year 2020. We recognize there may be circumstances beyond some applicants' or service providers' control that could prevent them from meeting the 120-day invoice filing deadline for the RHC Program. For example, an Administrator error, administrative process, or system

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<sup>566</sup> See, e.g., SCF Comments at 6; NACHC Comments at 20; AHA Comments at 18.

<sup>567</sup> See ACS Comments at 40.

<sup>568</sup> See USF Consultants Comments at 1.

<sup>569</sup> See 47 CFR § 54.645(b) (requiring all Healthcare Connect Fund Program invoices to be received by the Administrator within six months (180 days) of the end of the funding commitment).

<sup>570</sup> See 47 CFR § 54.627(b), as adopted herein; Appendix. A, Final Rules.

<sup>571</sup> See *Rural Health Care Support Mechanism*, WC Docket 02-60, Order, 30 FCC Rcd 1063, 1065, para. 6 (WCB 2015) (reminding applicants that adherence to the filing deadlines and program rules are necessary for the efficient administration of the Healthcare Connect Fund Program); *Request for Review by Portland Area Indian Health Service, Rural Health Care Universal Service Support Mechanism*, WC Docket No. 02-60, Order, 25 FCC Rcd 13050, 13053, para. 7 (WCB 2010) ("All applicants must comply with our rules and procedures and continue to submit complete and accurate information to [the Administrator] as part of the application review process.").

<sup>572</sup> *Modernizing the E-Rate Program for Schools and Libraries*, WC Docket No. 13-184, Order and Further Notice of Proposed Rulemaking, 29 FCC Rcd 8870, 8966, para. 238 (2014) (*2014 First E-Rate Order*).

<sup>573</sup> See 47 CFR § 54.675(a)(4) (stating that "[a]ll funds collected that are unused shall be carried forward into subsequent funding years for use in the Rural Health Care Program in accordance with the public interest and notwithstanding the annual cap").

<sup>574</sup> See 47 CFR § 54.627(b), as adopted herein; Appx. A, Final Rules.

<sup>575</sup> Compare 47 CFR § 54.627(b), as adopted herein; Appx. A, Final Rules with 47 CFR § 54.514(b) (E-Rate Program invoice deadline extension.).

issue may prevent or delay the timely submission of forms or invoices.<sup>576</sup> In other instances, a pending appeal of a specific funding request may impact the applicant's ability to submit invoices before the invoicing deadline. Therefore, we adopt a rule allowing service providers and billed entities to seek and receive from the Administrator a single one-time invoice extension for any given funding request, provided the extension request is made no later than the original invoice deadline.<sup>577</sup>

191. By adopting such a rule, we eliminate the need for applicants and service providers to identify a reason for the requested extension and the need for the Administrator to determine whether such timely requests meet certain criteria, which will ease the administrative burden of invoice extension requests on the Administrator. Additionally, it will provide applicants additional time to receive the service provider certification and for the service provider to submit the invoice to the Administrator.<sup>578</sup> We direct the Administrator to create a mechanism for service providers and billed entities to submit such extension requests.

192. *Strengthening Service Provider Certifications.* As part of our efforts to improve the invoicing process, we also strengthen the certifications made by the service provider when submitting invoices under the Telecom and Healthcare Connect Fund Programs.<sup>579</sup> Currently, the invoicing form for the Telecom Program requires the service provider to certify that "the information contained in the invoice is correct and the health care providers and the Billed Account Numbers listed above have been credited with the amounts shown under Support Amount to be Paid by [the Administrator]." <sup>580</sup> We take this opportunity to strengthen the certifications under the Telecom Program and require the service provider, in addition to the current certification above, to certify that: (1) it has abided by all program requirements, including all applicable Commission rules and orders; (2) it has received and reviewed the Health Care Provider Support Schedule (HSS),<sup>581</sup> invoice form and accompanying documentation, and that the rates charged for the telecommunications services are accurate and comply with the Commission's rules; (3) the service provider's representative is authorized to submit the invoice on behalf of the service provider; (4) the health care provider paid the appropriate urban rate for the

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<sup>576</sup> See *Requests for Review or Waiver of Decisions by the Universal Service Administrative Company by Indiana Telehealth Network, et al. Mechanism*, WC Docket No. 02-60, Order, 33 FCC Rcd 12341 (WCB 2018) (granting an appeal where the appellant demonstrated that it was unable to file the Healthcare Connect Fund Program invoice form on a timely basis due to an Administrator technical system issue that prevented the filing of the invoice form).

<sup>577</sup> See 47 CFR § 54.627(b), as adopted herein; Appx. A, Final Rules; *supra* para. 188 (establishing a deadline for invoices). For applicants who have submitted a site or service substitution or SPIN change request where the Administrator has not yet issued a revised funding commitment letter, the applicant should submit an invoice deadline extension request if the invoice deadline is approaching.

<sup>578</sup> See generally USAC, *Invoice USAC*, <https://www.usac.org/rhc/healthcare-connect/SP/step05/default.aspx> (last visited July 2, 2019); USAC, *Invoicing*, <https://www.usac.org/rhc/telecommunications/service-providers/invoicing.aspx> (last visited July 2, 2019).

<sup>579</sup> See *2017 Promoting Telehealth Notice and Order*, 27 FCC Rcd at 10665, para. 103 (seeking comment on whether to require service providers under the Telecom Program to certify on each invoice submission that they have reviewed and complied with all applicable requirements for the program, including the applicable competitive bidding requirements); Office of Management and Budget, Office of Information and Regulatory Affairs, *OMB Control No: 3060-0804*, [https://www.reginfo.gov/public/do/PRAViewICR?ref\\_nbr=201606-3060-028#section4\\_anchor](https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201606-3060-028#section4_anchor) (last visited July 2, 2019).

<sup>580</sup> See USAC, *Submitting Invoices*, <https://www.usac.org/rhc/about/outreach/videos/Submitting-Invoices.aspx> (last visited July 2, 2019).

<sup>581</sup> The HSS is generated by the Administrator and is sent to the health care provider contact and service provider. The HSS provides a detailed report of the approved service(s) and support information for each health care provider and service provider. See USAC, *Support Schedule*, <https://www.usac.org/rhc/telecommunications/service-providers/step05/default.aspx> (last visited July 2, 2019).

telecommunications services; and (5) it has charged the health care provider for only eligible services prior to submitting the form and accompanying documentation.<sup>582</sup>

193. While the invoice form for the Healthcare Connect Fund Program requires a service provider to certify to the accuracy of the form and attachments, that its representative is authorized to make the certifications, and that it will apply the amount paid by the Administrator to the billing account of the health care provider, it does not include any certifications regarding compliance with our rules. We therefore also strengthen the certifications under the Healthcare Connect Fund Program and require the service provider, in addition to the current certifications, to certify that it has: (1) abided by all program requirements, including all applicable Commission rules and orders and (2) charged the health care provider for only eligible services prior to submitting the form.<sup>583</sup> The inclusion of these additional certifications on the invoicing forms does not impose any further burdens on service providers because, as participants in the RHC Program, they are already required to abide by RHC Program rules. These additional certifications simply serve as a reminder to service providers of their responsibilities under the RHC Program and help to further ensure compliance with the Commission's rules and program requirements as part of our ongoing efforts to reduce, waste, fraud, and abuse in the RHC Program.<sup>584</sup> These certifications will become effective for funding year 2020.

#### **5. Establishing and Codifying Program-Wide Site and Service Substitution and SPIN Change Procedures**

194. *Site and Service Substitutions.* We further align the RHC Programs by making the site and service substitution criteria under the Healthcare Connect Fund Program applicable to the Telecom Program.<sup>585</sup> In 2012, the Commission adopted site and service substitution procedures for the Healthcare Connect Fund Program.<sup>586</sup> Under these procedures, a consortium leader or health care provider may request a site and service substitution if: (1) the substitution is provided for in the contract, within the change clause, or constitutes a minor modification; (2) the site is an eligible health care provider and the service is an eligible service under the Healthcare Connect Fund Program; (3) the substitution does not violate any contract provision or state, Tribal or local procurement laws; and (4) the requested change is within the scope of the controlling request for services, including any applicable request for proposal used in the competitive bidding process.<sup>587</sup> Additionally, support is restricted to qualifying site and service substitutions that do not increase the total amount of support under the applicable funding commitment.<sup>588</sup>

195. The Commission found that allowing site and service substitutions decreased burdens on program participants and increased administrative efficiencies by allowing applicants to request the Administrator to substitute or modify a site or service without modifying the actual funding commitment letter.<sup>589</sup> Moreover, the Commission found that these procedures recognized the changing broadband needs of health care providers by providing them with the flexibility to substitute alternative services if they satisfied certain criteria.<sup>590</sup> Despite these procedural and administrative benefits, the Commission

<sup>582</sup> The Telecom Program invoicing form will be revised as part of the Commission's information collection process to include these certifications.

<sup>583</sup> The Healthcare Connect Fund Program invoicing form (FCC Form 463) will be revised as part of the Commission's information collection process to include these certifications.

<sup>584</sup> See *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd at 10633-34, para. 4.

<sup>585</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16807, paras. 313-15; 47 CFR § 54.646.

<sup>586</sup> *Id.*

<sup>587</sup> 47 CFR § 54.646(a).

<sup>588</sup> *Healthcare Connect Fund Order*, 27 FCC Rcd at 16807, para. 315; 47 CFR § 54.646(b).

<sup>589</sup> *Healthcare Connect Fund Order*, 27 FCC Rcd at 16807, paras. 313-15.

<sup>590</sup> *Id.*

never adopted, and the Administrator has never established, similar procedures for the Telecom Program. Our new rule makes the site and service substitution criteria under the Healthcare Connect Fund Program applicable to the Telecom Program.<sup>591</sup> We believe that making these criteria applicable to both RHC Programs will decrease burdens on all program participants and increase administrative efficiencies by enabling applicants to request the Administrator to substitute or modify a site or service without modifying their funding commitment letter. This new rule will become effective for the Telecom Program for funding year 2020.<sup>592</sup>

196. We also require applicants under both the Healthcare Connect Fund and Telecom Programs to file requests for site and service substitutions with the Administrator by no later than the applicable service delivery deadline.<sup>593</sup> Applicants and service providers seeking funding under the RHC Program are currently required to submit invoices for the services they are seeking funding for by the invoicing deadline.<sup>594</sup> Applicants often file requests for site and service substitutions on or near the invoicing deadline, which increases administrative burdens on the Administrator and causes delays in the funding disbursement process. We believe that requiring applicants under the RHC Program to submit requests for site and service substitution by no later than the applicable service delivery deadline will ensure that the Administrator has ample time to review such requests prior to the invoicing deadline or the extension thereof.<sup>595</sup> This change will become effective funding year 2020 for all applicants under the RHC Program.

197. *SPIN Changes.* To further improve the administration of the RHC Program, we adopt rules, similar to those used in the E-Rate Program, governing requests for SPIN changes applicable to both the Telecom and the Healthcare Connect Fund Programs.<sup>596</sup> A SPIN is a unique number that the Administrator assigns to an eligible service provider seeking to participate in the universal service support mechanisms.<sup>597</sup> When requesting funding under the RHC Program, an applicant must use the SPIN to identify its chosen service provider when filing an FCC Form 462 (Healthcare Connect Fund Program) or an FCC Form 466 (Telecom Program).<sup>598</sup> An applicant may change the SPIN on its FCC Form 462 or FCC Form 466 by filing a written request with the Administrator.<sup>599</sup> While the Administrator has general

<sup>591</sup> See 47 CFR § 54.624, as adopted herein, Appx. A, Final Rules.

<sup>592</sup> The implementation of a program-wide rule does not change the current site and service substitution procedures for the Healthcare Connect Fund Program; therefore, no approval under the Paperwork Reduction Act (PRA) is required for the Healthcare Connect Fund Program.

<sup>593</sup> See Part III.E.3 (discussing the service delivery deadline); 47 CFR § 54.624(b) as adopted herein, Attachment A, Final Rules.

<sup>594</sup> See 47 CFR § 54.645(b) (requiring all Healthcare Connect Fund Program invoices to be received by the Administrator within six months (180 days) of the end of the funding commitment); 47 CFR § 54.627, as adopted herein; Appx. A, Final Rules; *see also, supra*, paras. 188-89.

<sup>595</sup> See Part III.E.3 (discussing the service delivery deadline) and Part III.E.4 (discussing the invoicing deadline).

<sup>596</sup> See 47 CFR § 54.625, as adopted herein, Appx. A, Final Rules.

<sup>597</sup> See USAC, *Obtain a 498 ID*, <https://www.usac.org/sp/about/obtain-498ID/default.aspx> (last visited July 2, 2019). To obtain a SPIN, a service provider must file an FCC Form 498 with the Administrator. *Id.*

<sup>598</sup> See USAC, *Health Care Providers, Submit Funding Requests*, <https://www.usac.org/rhc/telecommunications/health-care-providers/step04/default.aspx> (last visited Jul 2, 2019); USAC, *Individual, Submit Funding Requests*, <https://www.usac.org/rhc/healthcare-connect/individual/step06/> (last visited July 2, 2019); USAC, *Consortia, Submit Funding Requests*, <https://www.usac.org/rhc/healthcare-connect/consortia/step07/default.aspx> (last visited July 2, 2019); USAC, *Rural Health Care Program*, <https://www.usac.org/rhc/> (last visited July 2, 2019).

<sup>599</sup> See USAC, *Rural Health Care, Telecommunications Program, Service Providers, Information Changes*, <https://www.usac.org/rhc/telecommunications/service-providers/information-changes.aspx> (last visited July 2, 2019).



procedures for implementing SPIN changes, there are no established program-wide procedures for the RHC Program.<sup>600</sup>

198. To establish consistency between the universal service programs and provide guidance to RHC program participants, the SPIN change rules we adopt today are modeled after the SPIN change procedures established under the E-Rate Program.<sup>601</sup> As part of these rules, we define “corrective” SPIN changes as any “amendment to the SPIN associated with a Funding Request Number that does not involve a change to the service provider associated with that Funding Request Number.”<sup>602</sup> Similar to the E-Rate Program, an applicant may request a “corrective” SPIN change if the applicant is: (1) correcting data entry errors (e.g. fixing clerical errors such naming the correct service provider in the funding request but providing the incorrect SPIN); (2) updating a service provider’s SPIN that has changed due to the merger of companies or the acquisition of one company by another; or (3) effectuating a change that was not initiated by the applicant.<sup>603</sup> We also define “operational” SPIN changes as “any change to the service provider associated with a specific Funding Request Number.”<sup>604</sup> We will limit “operational” SPIN changes to situations where: (1) the applicant has a legitimate reason to change providers (e.g., breach of contract or the service provider is unable to perform); and (2) the applicant’s newly selected service provider received the next highest point value in the original bid evaluation, assuming there were multiple bidders.<sup>605</sup>

199. Additionally, we will require applicants to file requests for either a “corrective” or “operational” SPIN change in a manner prescribed by the Administrator by no later than the service delivery deadline as defined by the rules.<sup>606</sup> Accordingly, we direct the Administrator to implement procedures for requesting either a corrective or operational SPIN change consistent with our new rules and this Report and Order. We believe that the rules we adopt today will provide applicants with clarity on what we consider to be permissible SPIN changes under the RHC Program. Further, we believe that requiring applicants to file their requests by no later than the service delivery date will help alleviate the administrative burdens on the Administrator and reduce the number of requests for waiver of the invoicing deadline filed with the Commission. These rules will become effective for funding year 2020.

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<sup>600</sup> Such requests generally fall into one of the following three categories: (1) requests to correct data entry errors (e.g., fixing clerical errors or situations where the applicant names the correct service provider in the funding request but provides the incorrect SPIN); (2) requests to update a service provider’s SPIN that has changed due to the merger of companies or the acquisition of one company by another; or (3) requests to change a SPIN where the applicant has not initiated the change (e.g., where the service provider declares bankruptcy). As part of this written request, an applicant must also certify that the SPIN change is “allowed under all applicable state and local procurement rules and under the terms of the contract, if any, between the applicant and its original service provider.” The applicant must also certify that it “notified its original service provider of its intent to change service providers.” In the event that the applicant’s original service provider is no longer in business, the applicant must instead certify that it “attempted to notify its original service provider of its intent to change service providers but could not because the service provider is not available for contact.” See USAC, *Information Changes*, <https://www.usac.org/rhc/telecommunications/service-providers/information-changes.aspx> (last visited July 2, 2019).

<sup>601</sup> See 47 CFR § 47 CFR 54.625, as adopted herein, Appx. A, Final Rules, *compare with* USAC, Schools and Libraries, *Before You’re Done*, <https://www.usac.org/sl/applicants/before-youre-done/spin-changes/default.aspx> (last visited July 2, 2019).

<sup>602</sup> See 47 CFR § 54.625, as adopted herein, Appx. A, Final Rules.

<sup>603</sup> *Compare id. with* USAC, Schools and Libraries, *Before You’re Done*, <https://www.usac.org/sl/applicants/before-youre-done/spin-changes/default.aspx> (last visited July 2, 2019).

<sup>604</sup> *Id.*

<sup>605</sup> *Id.*

<sup>606</sup> *Id.*

## 6. Consolidating and Simplifying RHC Program Rules

200. As part of our efforts to streamline the RHC Program, we consolidate duplicative rules that exist between the Telecom and Healthcare Connect Fund Programs.<sup>607</sup> For example, we merge sections 54.619 (Telecom Program) and 54.648 (Healthcare Connect Fund Program) of the current rules into a single program-wide rule governing audits and recordkeeping.<sup>608</sup> We also create a single program-wide competitive bidding rule that combines the existing rules under the Telecom and Healthcare Connect Fund Programs, as amended and harmonized herein.<sup>609</sup> Further, we include some additional definitions in other sections of the current rules into the “Definitions” section.<sup>610</sup> We include those merged rules, and the new rules adopted by this Report and Order that apply, for the most part, to both the Telecom and Healthcare Connect Fund Programs, under the “General Provisions” section of the RHC Program rules.<sup>611</sup> All rules specifically applicable to either the Telecom or Healthcare Connect Fund Program will remain under separate sections within our rules.<sup>612</sup> We have, to the extent possible, in consolidating the rules, retained the language of the current rules.

201. As reflected in Appendix A, we have also reorganized and renumbered the RHC Program rules to reflect our consolidation efforts. Moreover, where necessary, we have simplified the language in our rules to use plain language so they are more easily understood by RHC Program stakeholders.<sup>613</sup> Once these rules are published in the Federal Register, we encourage RHC Program participants to familiarize themselves with the rules and the new format of the RHC Program rules.<sup>614</sup> We believe that these changes to our rules will reduce the administrative burdens on RHC Program stakeholders by making the rules easier to read and providing clarity on which rule requirements are program specific and which are program-wide. It will also help ensure that future amendments to program rules that apply to all RHC Program participants are implemented consistently in the Code of Federal Regulations.

202. Given the complexities associated with reforming the RHC Program and modifying our rules, we direct the Wireline Competition Bureau to make any further ministerial rule revisions as necessary to ensure the changes to the RHC Program adopted in this Report and Order are properly codified. This includes correcting any technical or textual conflicts between new and/or revised rules and existing rules, as well as addressing any technical or textual omissions or oversights.<sup>615</sup> If any such

<sup>607</sup> See Appx. A, Final Rules.

<sup>608</sup> Compare 47 CFR §§ 54.619, 54.648 with 47 CFR § 54.631, as adopted herein; Appx. A, Final Rules (consolidating the rules governing audits and recordkeeping).

<sup>609</sup> See 47 CFR § 54.622 as adopted herein; Appx. A, Final Rules.

<sup>610</sup> See 47 CFR § 54.600, as adopted herein; Appx. A, Final Rules.

<sup>611</sup> See 47 CFR §§ 54.619 through 54.633, as adopted herein; Appx. A, Final Rules.

<sup>612</sup> See 47 CFR §§ 54.603 through 54.606 (Telecom Program) and §§ 54.607 through 54.618 (Healthcare Connect Fund Program), as adopted herein; Appx. A, Final Rules.

<sup>613</sup> See Plain Writing Act of 2010, Pub. L. No. 111-274 (2010). The Commission is required to use plain writing that is “clear, concise, well-organized, and follows other best practices appropriate to the subject or field and intended audience” in all documents. See *infra* note 625 (requiring the Administrator to also use plain language in its correspondence with RHC Program participants).

<sup>614</sup> We note that, in consolidating the RHC Program rules, the section numbering has significantly changed, so RHC Program participants will need to reference the new rules when submitting appeals to the Administrator or the Commission. All newly-adopted, or newly-amended rules will become effective immediately upon announcement in the Federal Register of the Office of Management and Budget (OMB) approval.

<sup>615</sup> See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Third Report and Order, 12 FCC Rcd 22485, 22488-89, para. 6 (1997) (providing the Wireline Competition Bureau with delegated authority to address unanticipated technical and operational issues that will require prompt attention but will not warrant Commission review).

ministerial rule changes are warranted, the Wireline Competition Bureau shall be responsible for such changes.

**F. Improving the Application Process and Program Oversight**

203. In this section, we direct the Administrator to take a variety of actions to simplify the RHC Program's application process, increase transparency in the RHC Program, and ensure that all applicants receive complete and timely information to help inform their decisions regarding RHC eligible services and purchases.

**1. Streamlining and Improving the RHC Program Forms and Data Collection**

204. As part of our efforts to simplify and improve the efficiency of the application process for RHC Program participants, we direct the Administrator to streamline the data collection requirements and consolidate the RHC Program online forms in order to reduce the administrative burden on RHC Program participants. The record strongly supports making procedural improvements to the process that will reduce the time it takes the Administrator to issue funding commitment decisions.<sup>616</sup> Specifically, to the extent possible, we direct the Wireline Competition Bureau to work with the Administrator to streamline the data collection requirements and consolidate the program forms.<sup>617</sup> We also direct the Wireline Competition Bureau to work with the Administrator to align the data collections between the Healthcare Connect Fund and Telecom Programs, to the extent possible, for ease of use and consistency between the Programs.

205. We recognize, that in some instances, it may be necessary to include some additional data elements to certain online forms to harmonize the RHC Program and ensure compliance with the Commission's rules and procedures (e.g., requiring RHC Program applicants to list the requested services for which they seek bids,<sup>618</sup> including service provider certifications on the invoice forms to ensure that the rates charged for services are accurate and that services are eligible).<sup>619</sup> We also realize that some changes to the data collection requirements may be dependent upon the changes made to the RHC information technology systems. To the extent certain changes can be made to the data collection requirements within the existing RHC information technology systems, and do not require approval pursuant to the Paperwork Reduction Act, the Administrator will implement such changes so that they will become effective for funding year 2020. All other changes to the data collection requirements shall become effective no later than funding year 2021. Making this process easier for RHC Program applicants will reduce the administrative cost for health care providers by reducing the need for hiring skilled professionals to navigate the process and reducing the number of hours spent on completing the forms.<sup>620</sup>

206. Additionally, as part of the improving the application process, the Administrator shall provide RHC Program participants with direction on the proper use of all the forms by posting a guide for

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<sup>616</sup> See, e.g., BBAHC Comments at 8; NSHC Comments at 9; CATG Comments at 7; ANTHC Comments at 10; Manilaq Comments at 7; ANHB Comments at 8; CHC Comments at 2; TeleQuality Comments at 22-23; ADA Comments at 4.

<sup>617</sup> See, e.g., NOSOTH Comments at 5; YKHC Comments at 3; AHA Comments at 17-18; NCTA Comments at 8-9; KSLLC Comments at 15; SHLB Reply Comments at 14-15; INCOMPAS Reply Comments at 8; KSLLC Reply Comments at 17 (supporting an integrated application process).

<sup>618</sup> Improvements to the Commission's RHC Program competitive bidding rules are discussed in more detail in Part III.D.

<sup>619</sup> See *supra* paras. 192-93.

<sup>620</sup> See, e.g., FACHC Comments at 2; CPCA Comments at 2; NACHC Comments at 20 (supports efforts to simplify the application and funding process so that it no longer disadvantages and discourages small providers from participating); NRHA Comments at 5.

each form which includes screenshots and instructions for completing and submitting each form.<sup>621</sup> This will help those applicants who are new to the RHC Program or only occasionally participate in the program with guidance on how to complete the forms and the ability view screenshots of various sections of the form in order to better understand in advance how each section relates to other sections within a form.<sup>622</sup> Because the RHC Program includes both large and small stakeholders, the Administrator should be particularly careful to draft the form instructions, and all other correspondence from the Administrator to RHC Program participants, in a simple, direct, user-friendly, and helpful manner.<sup>623</sup> We believe that these improvements to the Administrator's application process and communications will reduce applicant confusion, ensure parties have the information necessary to comply with our rules and the Administrator's procedures, and expedite the application process. These requirements will become effective for funding year 2020.

## **2. Ensuring Effective Procedures for Program Administration**

207. The Administrator enforces and implements the Commission's rules and performs its functions as the Administrator of the RHC Program, through various administrative procedures. In the E-Rate Program, the Administrator submits its administrative procedures for application review to the Wireline Competition Bureau for approval on an annual basis,<sup>624</sup> and submits its administrative procedures for other functions at the Wireline Competition Bureau's request. This process enables the Wireline Competition Bureau to assess whether the Administrator's procedures sufficiently address the requirements of our rules, and to better understand the demands that are being made of program participants to demonstrate their compliance with our rules.

208. Given the increasing demand for limited RHC Program funds, it is imperative that the Administrator carefully review funding applications to ensure that support is distributed in accordance with our rules, including the new measures that we adopt in this Report and Order. It is also critically important that the Administrator's post-commitment processes, including invoicing, appeals, and recovery actions, are implemented efficiently and in accord with our precedent. At the same time, the Commission is committed to making participation in the RHC Program as straight-forward and predictable as possible. Health care providers and service providers should be required to demonstrate compliance with RHC Program rules to receive funding and should also understand the questions being asked, why they are being asked those questions, and what data and documents are required to answer those questions. There should also be a clear process for each potential step of a funding request's life cycle – from the filing of an application through disbursements or review of a decision by the Administrator – so that RHC Program participants can understand the status of their requests and advocate for them as necessary.

209. To effectuate these ends and enable the Commission to perform its oversight role, we direct the Administrator to document all of its administrative procedures for the RHC Program, including procedures for measures adopted by this Report and Order, and submit them to the Commission staff for

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<sup>621</sup> See ADA Comments at 4; SHLB Comments at 14-15.

<sup>622</sup> SHLB Comments at 14-15.

<sup>623</sup> This includes providing applicants with a detailed reason when denying a form or application so the applicant understands the basis for the denial. See SHLB Reply Comments at 14-15. The Commission is required to use plain writing that is "clear, concise, well-organized, and follows other best practices appropriate to the subject or field and intended audience" in all documents. Plain Writing Act of 2010, Pub. L. No. 111-274 (2010). Thus, the Administrator shall also use clear and concise writing when communicating with RHC Program participants.

<sup>624</sup> See FCC, USAC, *Memorandum of Understanding* (Dec. 19, 2018), <https://www.fcc.gov/sites/default/files/usac-mou.pdf>.

review and approval.<sup>625</sup> Specifically, we direct the Administrator to submit to the Wireline Competition Bureau within 90 days from publication of this Report and Order in the Federal Register, and annually thereafter, comprehensive, consolidated, written procedures for: (1) application review; (2) post-commitment reviews (e.g., SPIN changes); (3) recovery actions; (4) invoicing; (5) appeals; and (6) any other procedures as further directed by the Wireline Competition Bureau. The Wireline Competition Bureau will review the procedures to determine whether further action is needed and whether such procedures should be adopted. We believe formalizing the annual review and approval process for RHC Program procedures will promote greater transparency, efficiency, and timeliness regarding review of RHC Program forms and appeals and will enable quicker decisions for RHC Program participants. We direct the Wireline Competition Bureau to oversee the format for the submission of these procedures and the timeline going forward for submitting the annual RHC Program procedures to the Wireline Competition Bureau for review and approval.<sup>626</sup>

210. *Outreach.* We recognize that program participants will have questions about how the reforms adopted by this Report and Order will be implemented and how they can best prepare for the substantive and procedural changes.<sup>627</sup> Although we conclude that the effective dates established for the new rules provide sufficient time for health care and service providers to make any necessary adjustments, particularly given that the new rules reduce and streamline their procedural obligations, we understand that they need clear information to successfully navigate the reformed RHC Program. Accordingly, we direct the Administrator to prepare a series of outreach materials that set forth step-by-step requirements for health care and service providers under the new program rules. The outreach materials should include, at a minimum:<sup>628</sup> (1) filing guides setting forth the requirements of each form or online submission that health care and service providers are required to submit to the Administrator; (2) webinars separately addressing what health care and service providers must do to successfully participate in the Telecom Program and the Healthcare Connect Fund Program, from eligibility determinations through funding decisions and all post-commitment activities; and (3) updates to the Administrator's website providing the aforementioned information and materials. We further direct the Administrator to collect the questions that it receives about the implementation of the new rules, identify the most commonly asked questions, and prepare answers to those questions that can be posted on its website in a Questions and Answers section.<sup>629</sup> We believe that providing clear and easily accessible information to program participants about the implementation of the new rules will ease their concerns about transitioning to them and allow them to take full advantage of the more predictable, transparent, and streamlined processes.

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<sup>625</sup> See generally BBAHC Comments at 8; NSH Comments at 9; CATG Comments at 7; ANTHC Comments at 10; Maniilaq Comments at 7; ANHB Comments at 8 (supporting any procedural improvements that will reduce the time it takes the Administrator to issue funding commitment decisions).

<sup>626</sup> To facilitate the orderly implementation of the reforms adopted by this Report and Order and ensure that the Administrator continues to improve its administration of the RHC Program in a manner that is consistent with the Commission's rules and goals, we direct the Administrator to submit comprehensive plans for the administration of the RHC Program to the Wireline Competition Bureau and the Office of the Managing Director on an annual basis. We direct the Wireline Competition Bureau and the Office of the Managing Director to advise the Administrator of the content and format requirements necessary for the Commission's staff to efficiently perform our oversight functions. We further direct the Wireline Competition Bureau and the Office of the Managing Director to require the Administrator to revise the annual plans as necessary to address developments affecting the program.

<sup>627</sup> See ANHB July 24, 2019 *Ex Parte* Letter at 2; Alaska Primary Care July 24, 2019 *Ex Parte* Letter at 1-2.

<sup>628</sup> We require that the Administrator submit all outreach materials, and any further updates to the outreach materials, to the Wireline Competition Bureau for review and approval.

<sup>629</sup> We direct the Administrator to periodically update the Questions and Answers section to address questions that commonly arise as the new rules go into effect.



### 3. Promoting Data Quality and Transparency

211. As part of our efforts to improve transparency into the RHC Program, we direct the Administrator to continue to timely publish through electronic means all non-confidential RHC data in open, standardized, electronic formats, consistent with the [Open, Public, Electronic and Necessary \(OPEN\) Government Data Act](#).<sup>630</sup> In doing so, we recognize the efforts already made by the Administrator to publicize RHC Program data taken from the RHC FCC Forms in an open, electronic format. In July 2019, the Administrator released initial RHC Program data on its website, including information related to commitments and disbursements.<sup>631</sup> We direct the Administrator to provide a robust dataset that includes information on the type of services being requested and the rates charged by service providers for services provided to health care providers similar to the type of information provided for the E-Rate Program as part of the Administrator's Open Data.<sup>632</sup> The Administrator shall continue to provide the public with the ability to easily view and download non-confidential RHC Program data, for both individual datasets and aggregate data.<sup>633</sup> The Administrator must also design open and accessible data solutions in a modular format to allow extensibility and agile development, such as providing for the use of application programming interfaces (APIs) where appropriate and releasing the code, as open source code, where feasible. The Administrator's solutions must also be accessible to people with disabilities, as is required for federal agency information technology.<sup>634</sup> Additionally, the solutions must meet the federal information security and privacy requirements.<sup>635</sup>

212. The record supports the Administrator releasing RHC Program data in as open a manner as possible so that health care providers that receive support from the RHC Program and their associated service providers can view funding request and pricing information, track the status of their RHC applications and requests for discounts, and so that they, and the public at large, can benefit from greater program transparency and public accountability.<sup>636</sup> Commenters also assert that making RHC Program funding requests publicly and readily available will promote increased competition in the RHC Program and help to reduce waste, fraud, and abuse in the program.<sup>637</sup> Further, making non-confidential RHC data open and accessible will allow members of the public to develop new and innovative methods to analyze RHC Program data, which will benefit all stakeholders, including the Commission, as we continue to improve the RHC Program. Releasing RHC Program data in this manner should also enable greater

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<sup>630</sup> See Foundations for Evidence-Based Policymaking Act of 2017, Pub. L. No. 115-435, 132 Stat. 5529 (2019), (which includes the OPEN Data Act (Title II)); USAC, *USAC Open Data*, <https://opendata.usac.org/> (last visited Mar. 20, 2019).

<sup>631</sup> See *RHC Program Open Data Platform*.

<sup>632</sup> *E-Rate Program Open Data Platform*.

<sup>633</sup> This includes non-confidential supporting documentation submitted to the Administrator.

<sup>634</sup> Section 508 of the Rehabilitation Act of 1973 requires federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. Under Section 508, agencies must give disabled employees and members of the public access to information comparable to the access available to others. See 29 U.S.C. § 794 (d); General Services Administration, Section508.gov, *IT Accessibility Laws and Policy*, <https://www.section508.gov/manage/laws-and-policies> (last visited Mar. 20, 2019).

<sup>635</sup> See, e.g., Nat'l Inst. of Standards & Tech., *Security and Privacy Controls for Federal Information Systems and Organizations* (Apr. 2013), <https://csrc.nist.gov/publications/detail/sp/800-53/rev-4/final>.

<sup>636</sup> See, e.g., USTelecom Comments at 15-16, 23-24; SHLB Comments at 34, ADS Comments at 2-3; NCTA Comments at 5, 9; ACS Comments at 42; ADS Reply Comments at 1; SHLB Reply Comments 16-17; TeleQuality Reply Comments 14-15; AT&T Reply Comments at 11; ACS Reply Comments at 27-29, 43-44; KSLLC Reply Comments at 20-21; INCOMPAS Reply Comments at 8.

<sup>637</sup> See, e.g., USTelecom Comments at 15-16; ACS Comments at 42; AT&T Reply Comments at 11, ACS Reply Comments at 27-29.

integration with other datasets such as those maintained by the Health Resources & Services Administration (HRSA)'s Federal Office of Rural Health Policy.<sup>638</sup> This integration will create opportunities for new and innovative analyses about connectivity to our nation's health care facilities to support medical care to rural communities.

#### G. Implementation Schedule

213. RHC Program reforms will be effective 30 days after publication of the Report and Order and Final Rules in the Federal Register unless specifically identified below or if a rule contains an "information collection" subject to approval under the Paperwork Reduction Act. Because there are several interlocking changes to our rules, we summarize here when certain rules will take effect to ease the burden on program applicants.

214. In funding year 2020, rules for prioritizing funding if demand exceeds the available funding, rules governing majority-rural requirement for Healthcare Connect Fund Program, consortia certification rules, competitive bidding rules, invoicing rules, site and service substitutions and SPIN change rules, service delivery deadline and extension rules, gift rules, and rules governing use of consultants and other third parties will all take effect. In funding year 2021, the rules for determining urban and rural rates in the Telecom Program, the rule providing additional time to complete the competitive bidding process, and the application filing window rule will take effect.

#### IV. PROCEDURAL MATTERS

215. *Paperwork Reduction Analysis.* This Report and Order contains new and modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law No. 104-13. It will be submitted to the Office of Management and Budget (OMB) for review under section 3507(d) of the PRA. OMB, the general public, and other Federal agencies will be invited to comment on the new and modified information collection requirements contained in the proceeding. In addition, we note that pursuant to the Small Business Paperwork Relief Act of 2002,<sup>639</sup> we previously sought specific comment on how we might "further reduce the information collection burden for small business concerns with fewer than 25 employees."<sup>640</sup> We have described impacts that might affect small businesses, which includes most businesses with fewer than 25 employees, in the Final Regulatory Flexibility Analysis (FRFA), attached as Appendix B.

216. *Congressional Review Act.* The Commission will send a copy of this Report and Order to Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. § 801(a)(1)(A).

217. *Regulatory Flexibility Act.* The Regulatory Flexibility Act of 1980, as amended (RFA), requires that an agency prepare a regulatory flexibility analysis for notice and comment rulemakings, unless the agency certifies that "the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities."<sup>641</sup> The FRFA concerning the impact of the rule changes contained in the Report and Order is attached as Appendix B.

#### V. ORDERING CLAUSES

218. Accordingly, IT IS ORDERED, pursuant to the authority contained in sections 1-4, 201-205, 214, 254, 303(r), and 403 of the Communications Act of 1934, as amended, §§ 151 through 154, 201

<sup>638</sup> See HRSA, *Federal Office of Rural Health Policy*, <https://www.hrsa.gov/rural-health/index.html> (last visited July 2, 2019); *see also* Rural Health Information Hub, *Federal Agencies and Councils addressing Rural Health*, <https://www.ruralhealthinfo.org/organizations/federal-agencies-and-councils> (last visited July 2, 2019).

<sup>639</sup> Pub. L. No. 107-198.

<sup>640</sup> 44 U.S.C. § 3506(c)(4).

<sup>641</sup> 5 U.S.C. §§ 601 *et seq.*

through 205, 214, 254, 303(r), and 403, that this Report and Order is ADOPTED, effective thirty (30) days after publication of the text or summary thereof in the Federal Register, except that modifications to Paperwork Reduction Act burdens shall become effective immediately upon announcement in the Federal Register of OMB approval.

219. IT IS FURTHER ORDERED that Part 54 of the Commission's rules, 47 CFR Part 54 IS AMENDED as set forth in Appendix A, and such rule amendments shall be effective thirty (30) days after publication of the rule amendments in the Federal Register, except to the extent they contain information collections subject to PRA review. The rules that contain information collections subject to PRA review SHALL BECOME EFFECTIVE immediately upon announcement in the Federal Register of OMB approval.

220. IT IS FURTHER ORDERED that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this Report and Order, including the Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch  
Secretary

**APPENDIX A****FINAL RULES**

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 CFR part 54 to read as follows:

**PART 54 – UNIVERSAL SERVICE**

1. The authority citation for part 54 continues to read as follows:

Authority: 47 U.S.C. §§ 151, 154(i), 155, 201, 205, 214, 219, 220, 254, 303(r), 403, and 1302 unless otherwise noted.

2. Revise Subpart G to read as follows:

**DEFINED TERMS AND ELIGIBILITY**

- § 54.600 Terms and definitions.
- § 54.601 Health care provider eligibility.
- § 54.602 Health care support mechanism.

**TELECOMMUNICATIONS PROGRAM**

- § 54.603 Consortia, telecommunications services, and existing contracts.
- § 54.604 Determining the urban rate.
- § 54.605 Determining the rural rate.
- § 54.606 Calculating support.

**HEALTHCARE CONNECT FUND PROGRAM**

- § 54.607 Eligible recipients.
- § 54.608 Eligible service providers.
- § 54.609 Designation of consortium leader.
- § 54.610 Letters of agency.
- § 54.611 Health care provider contribution.
- § 54.612 Eligible services.
- § 54.613 Eligible equipment.
- § 54.614 Eligible participant-constructed and owned network facilities for consortium applicants.
- § 54.615 Off-site data centers and off-site administrative offices.
- § 54.616 Upfront payments.
- § 54.617 Ineligible expenses.
- § 54.618 Data collection and reporting.

**GENERAL PROVISIONS**

- § 54.619 Cap.
- § 54.620 Annual filing requirements and commitments.
- § 54.621 Filing window for requests and prioritization of support.
- § 54.622 Competitive bidding requirements and exemptions.
- § 54.623 Funding requests.
- § 54.624 Site and service substitutions.
- § 54.625 Service Provider Identification Number changes.
- § 54.626 Service delivery deadline and extension requests.
- § 54.627 Invoicing process and certifications.

§ 54.628 Duplicate support.

§ 54.629 Prohibition on resale.

§ 54.630 Election to offset support against annual universal service fund contribution.

§ 54.631 Audits and record keeping.

§ 54.632 Signature requirements for certifications.

§ 54.633 Validity of electronic signatures and records.

**§54.600 Terms and definitions.**

As used in this subpart, the following terms shall be defined as follows:

- (a) *Funding year.* A “funding year” for purposes of the funding cap shall be the period between July 1 of the current calendar year through June 30 of the next calendar year.
- (b) *Health care provider.* A “health care provider” is any:
  - (1) Post-secondary educational institution offering health care instruction, including a teaching hospital or medical school;
  - (2) Community health center or health center providing health care to migrants;
  - (3) Local health department or agency;
  - (4) Community mental health center;
  - (5) Not-for-profit hospital;
  - (6) Rural health clinic;
  - (7) Skilled nursing facility (as defined in section 395i–3(a) of Title 42); or a
  - (8) Consortium of health care providers consisting of one or more entities described in paragraphs (b)(1) through (7) of this section.
- (c) *Off-site administrative office.* An “off-site administrative office” is a facility that does not provide hands-on delivery of patient care but performs administrative support functions that are critical to the provision of clinical care by eligible health care providers.
- (d) *Off-site data center.* An “off-site data center” is a facility that serves as a centralized repository for the storage, management, and dissemination of an eligible health care provider’s computer systems, associated components, and data, including (but not limited to) electronic health records.
- (e) *Rural area.* A “rural area” is an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. For purposes of this rule, “Core Based Statistical Area,” “Urban Area,” and “Place” are as identified by the Census Bureau.
- (f) *Rural health care provider.* A “rural health care provider” is an eligible health care provider site located in a rural area.
- (g) *Urbanized area.* An “urbanized area” is an area with 50,000 or more people as designated by the Census Bureau based on the most recent decennial Census.

**§ 54.601 Health care provider eligibility.**

- (a) *Eligible health care providers.* (1) Only an entity that is either a public or non-profit health care provider, as defined in this subpart, shall be eligible to receive support under this subpart.



- (2) Each separate site or location of a health care provider shall be considered an individual health care provider for purposes of calculating and limiting support under this subpart.
- (b) *Determination of health care provider eligibility for the Healthcare Connect Fund Program.* Health care providers in the Healthcare Connect Fund Program may certify to the eligibility of particular sites at any time prior to, or concurrently with, filing a request for services to initiate competitive bidding for the site. Applicants who utilize a competitive bidding exemption must provide eligibility information for the site to the Administrator prior to, or concurrently with, filing a request for funding for the site. Health care providers must also notify the Administrator within 30 days of a change in the health care provider's name, site location, contact information, or eligible entity type.

**§ 54.602 Health care support mechanism.**

- (a) *Telecommunications Program.* Eligible rural health care providers may request support for the difference, if any, between the urban and rural rates for telecommunications services, subject to the provisions and limitations set forth in §§54.600 through 54.602 and §§54.603 through 54.606. This support is referred to as the "Telecommunications Program."
- (b) *Healthcare Connect Fund Program.* Eligible health care providers may request support for eligible services, equipment, and infrastructure, subject to the provisions and limitations set forth in §§54.600 through 54.602 and §§54.607 through 54.618. This support is referred to as the "Healthcare Connect Fund Program."
- (c) *Allocation of discounts.* An eligible health care provider that engages in both eligible and ineligible activities or that collocates with an ineligible entity shall allocate eligible and ineligible activities in order to receive prorated support for the eligible activities only. Health care providers shall choose a method of cost allocation that is based on objective criteria and reasonably reflects the eligible usage of the facilities.
- (d) *Health care purposes.* Services for which eligible health care providers receive support from the Telecommunications Program or the Healthcare Connect Fund Program must be reasonably related to the provision of health care services or instruction that the health care provider is legally authorized to provide under the law in the state in which such health care services or instruction are provided.

**TELECOMMUNICATIONS PROGRAM**

**§ 54.603 Consortia, telecommunications services, and existing contracts.**

- (a) *Consortia.* (1) Under the Telecommunications Program, an eligible health care provider may join a consortium with other eligible health care providers; with schools, libraries, and library consortia eligible under subpart F of this part; and with public sector (governmental) entities to order telecommunications services. With one exception, eligible health care providers participating in consortia with ineligible private sector members shall not be eligible for supported services under this subpart. A consortium may include ineligible private sector entities if such consortium is only receiving services at tariffed rates or at market rates from those providers who do not file tariffs.
- (2) For consortia, universal service support under the Telecommunications Program shall apply only to the portion of eligible services used by an eligible health care provider.
- (b) *Telecommunications services.* Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support. Upon submitting a bona fide request to a telecommunications carrier, each eligible rural health care provider is entitled to receive the most cost-effective, commercially-available telecommunications service, and a telecommunications service carrier that is eligible for support

under the Telecommunications Program shall provide such service at the urban rate, as defined in § 54.604.

- (c) *Existing contracts.* A signed contract for services eligible for Telecommunications Program support pursuant to this subpart between an eligible health care provider, as defined under §54.600, and a service provider shall be exempt from the competitive bid requirements as set forth in §54.622(i).

**§ 54.604 Determining the urban rate.**

- (a) *Urban rate.* An applicant shall use the applicable urban rate currently available in the Administrator's database when requesting funding. The "urban rate" shall be the median of all available rates identified by the Administrator for functionally similar services in all urbanized areas of the state where the health care provider is located to the extent that urbanized area falls within the state.
- (b) *Database.* The Administrator shall create and maintain on its website a database that lists, by state, the eligible Telecommunications Program services and the related urban rate.

**§ 54.605 Determining the rural rate.**

- (a) *Rural rate.* An applicant shall use the lower of the applicable "rural rate" currently available in the Administrator's database or the rural rate included in the service agreement that the health care provider enters into with the service provider when requesting funding. The rural rate will be determined using the following tiers in which a health care provider is located: (1) *Extremely Rural* – areas entirely outside of a Core Based Statistical Area; (2) *Rural* – areas within a Core Based Statistical Area that does not have an Urban Area with a population of 25,000 or greater; (3) *Less Rural* – areas in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but are within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000; and for health care providers located in Alaska only, (4) *Frontier* – areas outside of a Core Based Statistical Area that are inaccessible by road as determined by the Alaska Department of Commerce, Community, and Economic Development, Division of Community and Regional Affairs. The "rural rate" shall be the median of all available rates for the same or functionally similar service offered within the rural tier, applicable to the health care provider's location within the state. The Administrator shall not include any rates reduced by universal service support mechanisms. The "rural rate" shall be used as described in this subpart to determine the credit or reimbursement due to a telecommunications carrier that provides eligible telecommunications services to eligible health care providers.
- (b) *Database.* The Administrator shall create and maintain on its website a database that lists, by state, the eligible Telecommunications Program services and the related rural rate for each such service and for each rural tier.
- (c) *Request for waiver.* A petition for a waiver of the "rural rate," as described in paragraph (a) of this section, may be granted if the service provider demonstrates that application of the rural rate published by the Administrator would result in a projected rate of return on the net investment in the assets used to provide the rural health care service that is less than the Commission-prescribed rate of return for incumbent rate of return local exchange carriers (LECs).

*Note to Paragraph (c).* All waiver requests must articulate specific facts that demonstrate that "good cause" exists to grant the requested waiver and that granting the requested waiver would be in the public interest. To satisfy this standard, the waiver request must be substantiated through documentary evidence as stated below. A waiver request will not be entertained if it does not also set forth a rural rate that the service provider demonstrates will permit it to obtain no more than the current Commission prescribed rate of return authorized for incumbent rate of return local exchange carriers.

Petitions seeking a waiver must include all financial data and other information to verify the service provider's assertions, including, at a minimum, the following information:

1. Company-wide and rural health care service gross investment, accumulated depreciation, deferred state and federal income taxes, and net investment; capital costs by category expressed as annual figures (e.g., depreciation expense, state and federal income tax expense, return on net investment); operating expenses by category (e.g., maintenance expense, administrative and other overhead expenses, and tax expense other than income tax expense); the applicable state and federal income tax rates; fixed charges (e.g., interest expense); and any income tax adjustments;
2. An explanation and a set of detailed spreadsheets showing the direct assignment of costs to the rural health care service and how company-wide common costs are allocated among the company's services, including the rural health care service, and the result of these direct assignments and allocations as necessary to develop a rate for the rural health care service;
3. The company-wide and rural health care service costs for the most recent calendar year for which full-time actual, historical cost data are available;
4. Projections of the company-wide and rural health care service costs for the funding year in question and an explanation of those projections;
5. Actual monthly demand data for the rural health care service for the most recent three calendar years (if applicable);
6. Projections of the monthly demand for the rural health care service for the funding year in question, and the data and details on the methodology used to make those projections;
7. The annual revenue requirement (capital costs and operating expenses expressed as an annual number plus a return on net investment) and the rate for the funded service (annual revenue requirement divided by annual demand divided by twelve equals the monthly rate for the service), assuming one rate element for the service), based on the projected rural health care service costs and demands;
8. Audited financial statements and notes to the financial statements, if available, and otherwise unaudited financial statements for the most recent three fiscal years, specifically, the cash flow statement, income statement, and balance sheets. Such statements shall include information regarding costs and revenues associated with, or used as a starting point to develop, the rural health care service rate;
9. Density characteristics of the rural area or other relevant geographical areas including square miles, road miles, mountains, bodies of water, lack of roads, remoteness, challenges and costs associated with transporting fuel, satellite and backhaul availability, extreme weather conditions, challenging topography, short construction season or any other characteristics that contribute to the high cost of servicing the health care providers.

**§ 54.606 Calculating support.**

- (a) The amount of universal service support provided for an eligible service to be funded from the Telecommunications program shall be the difference, if any, between the urban rate and the rural rate charged for the services, as defined herein. In addition, all reasonable charges that are incurred by taking such services, such as state and federal taxes, shall be eligible for universal service support. Charges for termination liability, penalty surcharges, and other charges not included in the cost of taking such service shall not be covered by the universal service support mechanisms.
- (b) The universal service support mechanisms shall provide support for intrastate telecommunications services, as set forth in § 54.101(a), provided to rural health care providers as well as interstate telecommunications services.

- (c) *Mobile rural health care providers—* (1) *Calculation of support.* The support amount allowed under the Telecommunications Program for satellite services provided to mobile rural health care providers is calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth. Support for satellite services shall not be capped at an amount of a functionally similar wireline alternative. Where the mobile rural health care provider provides service in more than one state, the calculation shall be based on the urban areas in each state, proportional to the number of locations served in each state.
- (2) *Documentation of support.* (i) Mobile rural health care providers shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services in the urban area in the state or states where the service is provided. Mobile rural health care providers shall provide to the Administrator the number of sites the mobile health care provider will serve during the funding year.
- (ii) Where a mobile rural health care provider serves less than eight different sites per year, the mobile rural health care provider shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services. In such case, the Administrator shall determine on a case-by-case basis whether the telecommunications service selected by the mobile rural health care provider is the most cost-effective option. Where a mobile rural health care provider seeks a more expensive satellite-based service when a less expensive wireline alternative is most cost-effective, the mobile rural health care provider shall be responsible for the additional cost.

#### HEALTHCARE CONNECT FUND PROGRAM

##### § 54.607 Eligible recipients.

- (a) *Rural health care provider site—individual and consortium.* Under the Healthcare Connect Fund Program, an eligible rural health care provider may receive universal service support by applying individually or through a consortium. For purposes of the Healthcare Connect Fund Program, a “consortium” is a group of two or more health care provider sites that request support through a single application. Consortia may include health care providers who are not eligible for support under the Healthcare Connect Fund Program, but such health care providers cannot receive support for their expenses and must participate pursuant to the cost allocation guidelines in § 54.617(d).
- (b) *Limitation on participation of non-rural health care provider sites in a consortium.* An eligible non-rural health care provider site may receive universal service support only as part of a consortium that includes more than 50 percent eligible rural health care provider sites. The majority-rural consortia percentage requirement will increase by 5 percent for the following funding year (up to a maximum of 75 percent) if the Commission must prioritize funding for a given year because Rural Health Care Program demand exceeds the funding cap.
- (c) *Limitation on large non-rural hospitals.* Each eligible non-rural public or non-profit hospital site with 400 or more licensed patient beds may receive no more than \$30,000 per year in Healthcare Connect Fund Program support for eligible recurring charges and no more than \$70,000 in Healthcare Connect Fund Program support every five years for eligible nonrecurring charges, exclusive in both cases of costs shared by the network.

##### § 54.608 Eligible service providers.

- (a) For purposes of the Healthcare Connect Fund Program, eligible service providers shall include any provider of equipment, facilities, or services that is eligible for support under the Healthcare Connect Fund Program.

**§ 54.609 Designation of Consortium Leader.**

- (a) *Identifying a Consortium Leader.* Each consortium seeking support under the Healthcare Connect Fund Program must identify an entity or organization that will lead the consortium (the “Consortium Leader”).
- (b) *Consortium Leader eligibility.* The Consortium Leader may be the consortium itself (if it is a distinct legal entity); an eligible health care provider participating in the consortium; or a state organization, public sector (governmental) entity (including a Tribal government entity), or non-profit entity that is ineligible for Healthcare Connect Fund Program support. Ineligible state organizations, public sector entities, or non-profit entities may serve as Consortium Leaders or provide consulting assistance to consortia only if they do not participate as potential service providers during the competitive bidding process. An ineligible entity that serves as the Consortium Leader must pass on the full value of any discounts, funding, or other program benefits secured to the consortium members that are eligible health care providers.
- (c) *Consortium Leader responsibilities.* The Consortium Leader’s responsibilities include the following:
  - (1) *Legal and financial responsibility for supported activities.* The Consortium Leader is the legally and financially responsible entity for the activities supported by the Healthcare Connect Fund Program. By default, the Consortium Leader is the responsible entity if audits or other investigations by Administrator or the Commission reveal violations of the Act or Commission rules, with individual consortium members being jointly and severally liable if the Consortium Leader dissolves, files for bankruptcy, or otherwise fails to meet its obligations. Except for the responsibilities specifically described in paragraph (c)(2) through (c)(6) of this section, consortia may allocate legal and financial responsibility as they see fit, provided that this allocation is memorialized in a formal written agreement between the affected parties (i.e., the Consortium Leader, and the consortium as a whole and/or its individual members), and the written agreement is submitted to the Administrator for approval with, or prior to, the request for services. Any such agreement must clearly identify the party(ies) responsible for repayment if the Administrator, at a later date, seeks to recover disbursements of support to the consortium due to violations of program rules.
  - (2) *Point of contact for the FCC and Administrator.* The Consortium Leader is responsible for designating an individual who will be the “Project Coordinator” and serve as the point of contact with the Commission and the Administrator for all matters related to the consortium. The Consortium Leader is responsible for responding to Commission and Administrator inquiries on behalf of the consortium members throughout the application, funding, invoicing, and post-invoicing period.
  - (3) *Typical applicant functions, including forms and certifications.* The Consortium Leader is responsible for submitting program forms and required documentation and ensuring that all information and certifications submitted are true and correct. The Consortium Leader must also collect and retain a Letter of Agency (LOA) from each member, pursuant to § 54.610.
  - (4) *Competitive bidding and cost allocation.* The Consortium Leader is responsible for ensuring that the competitive bidding process is fair and open and otherwise complies with Commission requirements. If costs are shared by both eligible and ineligible entities, the Consortium Leader must ensure that costs are allocated in a manner that ensures that only eligible entities receive the benefit of program discounts.
  - (5) *Invoicing.* The Consortium Leader is responsible for notifying the Administrator when supported services have commenced and for submitting invoices to the Administrator.



- (6) *Recordkeeping, site visits, and audits.* The Consortium Leader is also responsible for compliance with the Commission's recordkeeping requirements and for coordinating site visits and audits for all consortium members.

**§ 54.610 Letters of agency (LOA).**

- (a) *Authorizations.* Under the Healthcare Connect Fund Program, the Consortium Leader must obtain the following authorizations:
- (1) Prior to the submission of the request for services, the Consortium Leader must obtain authorization, the necessary certifications, and any supporting documentation from each consortium member to permit the Consortium Leader to submit the request for services and prepare and post the request for proposal on behalf of the member.
  - (2) Prior to the submission of the funding request, the Consortium Leader must secure authorization, the necessary certifications, and any supporting documentation from each consortium member to permit the Consortium Leader to submit the funding request and manage invoicing and payments on behalf of the member.
- (b) *Optional two-step process.* The Consortium Leader may secure both required authorizations from each consortium member in either a single LOA or in two separate LOAs.
- (c) *Required information in a LOA.* (1) An LOA must include, at a minimum, the name of the entity filing the application (i.e., lead applicant or Consortium Leader); the name of the entity authorizing the filing of the application (i.e., the participating health care provider/consortium member); the physical location of the health care provider/consortium member site(s); the relationship of each site seeking support to the lead entity filing the application; the specific timeframe the LOA covers; the signature, title and contact information (including phone number, mailing address, and email address) of an official who is authorized to act on behalf of the health care provider/consortium member; the signature date; and the type of services covered by the LOA.
- (2) For health care providers located on Tribal lands, if the health care facility is a contract facility that is run solely by the tribe, the appropriate Tribal leader, such as the Tribal chairperson, president, or governor, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another Tribal government representative.

**§ 54.611 Health care provider contribution.**

- (a) *Health care provider contribution.* All health care providers receiving support under the Healthcare Connect Fund Program shall receive a 65 percent discount on the cost of eligible expenses and shall be required to contribute 35 percent of the total cost of all eligible expenses.
- (b) *Limits on eligible sources of health care provider contribution.* Only funds from eligible sources may be applied toward the health care provider's required contribution.
- (1) Eligible sources include the applicant or eligible health care provider participants; state grants, appropriations, or other sources of state funding; federal grants, loans, appropriations except for other federal universal service funding, or other sources of federal funding; Tribal government funding; and other grants, including private grants.
  - (2) Ineligible sources include (but are not limited to) in-kind or implied contributions from health care providers; direct payments from service providers, including contractors and consultants to such entities; and for-profit entities.
- (c) *Disclosure of health care provider contribution source.* Prior to receiving support, applicants are required to identify with specificity their sources of funding for their contribution of eligible expenses.

- (d) *Future revenues from excess capacity as source of health care provider contribution.* A consortium applicant that receives support for participant-owned network facilities under § 54.614 may use future revenues from excess capacity as a source for the required health care provider contribution, subject to the following limitations:
- (1) The consortium's selection criteria and evaluation for "cost-effectiveness," pursuant to § 54.622(g)(1), cannot provide a preference to bidders that offer to construct excess capacity.
  - (2) The applicant must pay the full amount of the additional costs for excess capacity facilities that will not be part of the supported health care network.
  - (3) The additional cost of constructing excess capacity facilities may not count toward a health care provider's required contribution.
  - (4) The inclusion of excess capacity facilities cannot increase the funded cost of the dedicated health care network in any way.
  - (5) An eligible health care provider (typically the consortium, although it may be an individual health care provider participating in the consortium) must retain ownership of the excess capacity facilities. It may make the facilities available to third parties only under an indefeasible right of use (IRU) or lease arrangement. The lease or IRU between the participant and the third party must be an arm's length transaction. To ensure that this is an arm's length transaction, neither the service provider that installs the excess capacity facilities nor its affiliate is eligible to enter into an IRU or lease with the participant.
  - (6) Any amount prepaid for use of the excess capacity facilities (IRU or lease) must be placed in an escrow account. The participant can then use the escrow account as an eligible source of funds for the participant's 35 percent contribution to the project.
  - (7) All revenues from use of the excess capacity facilities by the third party must be used for the health care provider contribution or for the sustainability of the health care network supported by the Healthcare Connect Fund Program. Network costs that may be funded with any additional revenues that remain will include: administration costs, equipment, software, legal fees, or other costs not covered by the Healthcare Connect Fund Program, as long as they are relevant to sustaining the network.

**§ 54.612 Eligible services.**

- (a) *Eligible services.* Subject to the provisions of §§ 54.600 through 54.602 and §§ 54.607 through 54.633, eligible health care providers may request support under the Healthcare Connect Fund Program for any advanced telecommunications or information service that enables health care providers to post their own data, interact with stored data, generate new data, or communicate, by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.
- (b) *Eligibility of dark fiber.* A consortium of eligible health care providers may receive support for "dark" fiber where the customer, not the service provider, provides the modulating electronics, subject to the following limitations:
  - (1) Support for recurring charges associated with dark fiber is only available once the dark fiber is "lit" and actually being used by the health care provider. Support for non-recurring charges for dark fiber is only available for fiber lit within the same funding year, but applicants may receive up to a one-year extension to light fiber, consistent with § 54.626(b), if they provide documentation to the Administrator that construction was unavoidably delayed due to weather or other reasons.

- (2) Requests for proposals that solicit dark fiber solutions must also solicit proposals to provide the needed services over lit fiber over a time period comparable to the duration of the dark fiber lease or indefeasible right of use.
- (3) If an applicant intends to request support for equipment and maintenance costs associated with lighting and operating dark fiber, it must include such elements in the same request for proposal as the dark fiber so that the Administrator can review all costs associated with the fiber when determining whether the applicant chose the most cost-effective bid.
- (c) *Dark and lit fiber maintenance costs.* (1) Both individual and consortium applicants may receive support for recurring maintenance costs associated with leases of dark or lit fiber.
- (2) Consortium applicants may receive support for upfront payments for maintenance costs associated with leases of dark or lit fiber, subject to the limitations in § 54.616.
- (d) *Reasonable and customary installation charges.* Eligible health care providers may obtain support for reasonable and customary installation charges for eligible services, up to an undiscounted cost of \$5,000 per eligible site.
- (e) *Upfront charges for service provider deployment of new or upgraded facilities.* (1) Participants may obtain support for upfront charges for service provider deployment of new or upgraded facilities to serve eligible sites.
- (2) Support is available to extend service provider deployment of facilities up to the “demarcation point,” which is the boundary between facilities owned or controlled by the service provider, and facilities owned or controlled by the customer.

**§ 54.613 Eligible equipment.**

- (a) Both individual and consortium applicants may receive support for network equipment necessary to make functional an eligible service supported under the Healthcare Connect Fund Program.
- (b) Consortium applicants may also receive support for network equipment necessary to manage, control, or maintain an eligible service or a dedicated health care broadband network. Support for network equipment is not available for networks that are not dedicated to health care.
- (c) Network equipment eligible for support includes the following:
  - (1) Equipment that terminates a carrier’s or other provider’s transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment. This includes equipment required to light dark fiber, or equipment necessary to connect dedicated health care broadband networks or individual health care providers to middle mile or backbone networks;
  - (2) Computers, including servers, and related hardware (e.g., printers, scanners, laptops) that are used exclusively for network management;
  - (3) Software used for network management, maintenance, or other network operations, and development of software that supports network management, maintenance, and other network operations;
  - (4) Costs of engineering, furnishing (i.e., as delivered from the manufacturer), and installing network equipment; and
  - (5) Equipment that is a necessary part of health care provider-owned network facilities.
- (d) Additional limitations: Support for network equipment is limited to equipment:
  - (1) Purchased or leased by a Consortium Leader or eligible health care provider; and
  - (2) Used for health care purposes.

**§ 54.614 Eligible participant-constructed and owned network facilities for consortium applicants.**

- (a) Subject to the funding limitations of this subsection and the following restrictions, consortium applicants may receive support for network facilities that will be constructed and owned by the consortium (if the consortium is an eligible health care provider) or eligible health care providers within the consortium. Subject to the funding limitations under §§ 54.616 and 54.619 and the following restrictions, consortium applicants may receive support for network facilities that will be constructed and owned by the consortium (if the consortium is an eligible health care provider) or eligible health care providers within the consortium.
- (1) Consortia seeking support to construct and own network facilities are required to solicit bids for both:
  - (i) Services provided over third-party networks; and
  - (ii) Construction of participant-owned network facilities, in the same request for proposals. Requests for proposals must provide sufficient detail so that cost-effectiveness can be evaluated over the useful life of the proposed network facility to be constructed.
- (2) Support for participant-constructed and owned network facilities is only available where the consortium demonstrates that constructing its own network facilities is the most cost-effective option after competitive bidding, pursuant to § 54.622(g)(1).

**§ 54.615 Off-site data centers and off-site administrative offices.**

- (a) The connections and network equipment associated with off-site data centers and off-site administrative offices used by eligible health care providers for their health care purposes are eligible for support under the Healthcare Connect Fund Program, subject to the conditions and restrictions set forth in paragraph (b) of this section.
- (b) *Conditions and restrictions.* The following conditions and restrictions apply to support provided under this section.
  - (1) Connections eligible for support are only those that are between:
    - (i) Eligible health care provider sites and off-site data centers or off-site administrative offices;
    - (ii) Two off-site data centers;
    - (iii) Two off-site administrative offices;
    - (iv) An off-site data center and the public Internet or another network;
    - (v) An off-site administrative office and the public Internet or another network; or
    - (vi) An off-site administrative office and an off-site data center.
  - (2) The supported connections and network equipment must be used solely for health care purposes.
  - (3) The supported connections and network equipment must be purchased by an eligible health care provider or a public or non-profit health care system that owns and operates eligible health care provider sites.
  - (4) If traffic associated with one or more ineligible health care provider sites is carried by the supported connection and/or network equipment, the ineligible health care provider sites must allocate the cost of that connection and/or equipment between eligible and ineligible sites, consistent with the “fair share” principles set forth in § 54.617(d)(1).

**§ 54.616 Upfront payments.**

- (a) Upfront payments include all non-recurring costs for services, equipment, or facilities, other than reasonable and customary installation charges of up to \$5,000.

- (b) The following limitations apply to all upfront payments:
  - (1) Upfront payments associated with services providing a bandwidth of less than 1.5 Mbps (symmetrical) are not eligible for support.
  - (2) Only consortium applicants are eligible for support for upfront payments.
- (c) The following limitations apply if a consortium makes a request for support for upfront payments that exceeds, on average, \$50,000 per eligible site in the consortium:
  - (1) The support for the upfront payments must be prorated over at least three years.
  - (2) The upfront payments must be part of a multi-year contract.

**§ 54.617 Ineligible expenses.**

- (a) *Equipment or services not directly associated with eligible services.* Expenses associated with equipment or services that are not necessary to make an eligible service functional, or to manage, control, or maintain an eligible service or a dedicated health care broadband network are ineligible for support.

*Note to paragraph (a):* The following are examples of ineligible expenses:

- 1. Costs associated with general computing, software, applications, and Internet content development are not supported, including the following:
  - i. Computers, including servers, and related hardware (e.g., printers, scanners, laptops), unless used exclusively for network management, maintenance, or other network operations;
  - ii. End user wireless devices, such as smartphones and tablets;
  - iii. Software, unless used for network management, maintenance, or other network operations;
  - iv. Software development (excluding development of software that supports network management, maintenance, and other network operations);
  - v. Helpdesk equipment and related software, or services, unless used exclusively in support of eligible services or equipment;
  - vi. Web server hosting;
  - vii. Web site portal development;
  - viii. Video/audio/web conferencing equipment or services; and
  - ix. Continuous power source.
- 2. Costs associated with medical equipment (hardware and software), and other general health care provider expenses are not supported, including the following:
  - A. Clinical or medical equipment;
  - B. Telemedicine equipment, applications, and software;
  - C. Training for use of telemedicine equipment;
  - D. Electronic medical records systems; and
  - E. Electronic records management and expenses.
- (b) *Inside wiring/internal connections.* Expenses associated with inside wiring or internal connections are ineligible for support under the Healthcare Connect Fund Program.
- (c) *Administrative expenses.* Administrative expenses are not eligible for support under the Healthcare Connect Fund Program.



*Note to paragraph (c):* Ineligible administrative expenses include, but are not limited to, the following expenses:

1. Personnel costs (including salaries and fringe benefits), except for personnel expenses in a consortium application that directly relate to designing, engineering, installing, constructing, and managing a dedicated broadband network. Ineligible costs of this category include, for example, personnel to perform program management and coordination, program administration, and marketing;
2. Travel costs, except for travel costs that are reasonable and necessary for network design or deployment and that are specifically identified and justified as part of a competitive bid for a construction project;
3. Legal costs;
4. Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations;
5. Program administration or technical coordination (e.g., preparing application materials, obtaining letters of agency, preparing requests for proposals, negotiating with service providers, reviewing bids, and working with the Administrator) that involves anything other than the design, engineering, operations, installation, or construction of the network;
6. Administration and marketing costs (e.g., administrative costs; supplies and materials, except as part of network installation/construction; marketing studies, marketing activities, or outreach to potential network members; and evaluation and feedback studies);
7. Billing expenses (e.g., expenses that service providers may charge for allocating costs to each health care provider in a network);
8. Helpdesk expenses (e.g., equipment and related software, or services); and
9. Technical support services that provide more than basic maintenance.

(d) *Cost allocation for ineligible sites, services, or equipment*—(1) *Ineligible sites*. Eligible health care provider sites may share expenses with ineligible sites, as long as the ineligible sites pay their fair share of the expenses. An applicant may seek support for only the portion of a shared eligible expense attributable to eligible health care provider sites. To receive support, the applicant must ensure that ineligible sites pay their fair share of the expense. The fair share is determined as follows:

(i) If the service provider charges a separate and independent price for each site, an ineligible site must pay the full undiscounted price.

(ii) If there is no separate and independent price for each site, the applicant must prorate the undiscounted price for the “shared” service, equipment, or facility between eligible and ineligible sites on a proportional fully-distributed basis. Applicants must make this cost allocation using a method that is based on objective criteria and reasonably reflects the eligible usage of the shared service, equipment, or facility. The applicant bears the burden of demonstrating the reasonableness of the allocation method chosen.

(2) *Ineligible components of a single service or piece of equipment*. Applicants seeking support for a service or piece of equipment that includes an ineligible component must explicitly request in their requests for proposals that service providers include pricing for a comparable service or piece of equipment that is comprised of only eligible components. If the selected service provider also submits a price for the eligible component on a stand-alone basis, the support amount is calculated based on the stand-alone price of the eligible component. If the service provider does not offer the eligible component on a stand-alone basis, the full price of the entire service or piece of equipment must be taken into account, without regard to the value of the ineligible components, when determining the most cost-effective bid.

- (3) *Written description.* Applicants must submit a written description of their allocation method(s) to the Administrator with their funding requests.
- (4) *Written agreement.* If ineligible entities participate in a network, the allocation method must be memorialized in writing, such as a formal agreement among network members, a master services contract, or for smaller consortia, a letter signed and dated by all (or each) ineligible entity and the Consortium Leader.

**§ 54.618 Data collection and reporting.**

- (a) Each applicant must file an annual report with the Administrator on or before September 30 for the preceding funding year, with the information and in the form specified by the Wireline Competition Bureau.
- (b) Each applicant must file an annual report for each funding year in which it receives support from the Healthcare Connect Fund Program.
- (c) For consortia that receive large upfront payments, the reporting requirement extends for the life of the supported facility.

**GENERAL PROVISIONS**

**§ 54.619 Cap.**

- (a) *Amount of the annual cap.* The aggregate annual cap on federal universal service support for health care providers shall be \$571 million per funding year, of which up to \$150 million per funding year will be available to support upfront payments and multi-year commitments under the Healthcare Connect Fund Program.
- (1) *Inflation increase.* In funding year 2018 and subsequent funding years, the \$571 million cap on federal universal support in the Rural Health Care Program shall be increased annually to take into account increases in the rate of inflation as calculated in paragraph (a)(2) of this section. In funding year 2020 and subsequent funding years, the \$150 million cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program shall also be increased annually to take into account increases in the rate of inflation as calculated in paragraph (a)(2) of this section.
- (2) *Increase calculation.* To measure increases in the rate of inflation for the purposes of paragraph (a)(1) herein, the Commission shall use the Gross Domestic Product Chain-type Price Index (GDP-CPI). To compute the annual increase as required by paragraph (a)(1), the percentage increase in the GDP-CPI from the previous year will be used. For instance, the annual increase in the GDP-CPI from 2017 to 2018 would be used for the 2018 funding year. The increase shall be rounded to the nearest 0.1 percent by rounding 0.05 percent and above to the next higher 0.1 percent. This percentage increase shall be added to the amount of the annual Rural Health Care Program funding cap and the internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program from the previous funding year. If the yearly average GDP-CPI decreases or stays the same, the annual Rural Health Care Program funding cap and the internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program shall remain the same as the previous year.
- (3) *Public notice.* After calculating the annual Rural Health Care Program funding cap and the internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program based on the GDP-CPI, the Wireline Competition Bureau shall publish a public notice in the Federal Register within 60 days announcing any increase of the annual funding cap based on the rate of inflation.
- (4) *Amount of unused funds.* All unused collected funds shall be carried forward into subsequent funding years for use in the Rural Health Care Program in accordance with the public interest and

notwithstanding the annual cap. The Administrator, on a quarterly basis, shall report to the Commission on unused Rural Health Care Program funding from prior years.

- (5) *Application of unused funds.* On an annual basis, in the second quarter of each calendar year, all unused collected funds from prior years shall be available for use in the next full funding year of the Rural Health Care Program notwithstanding the annual cap as described in paragraph (a). The Wireline Competition Bureau, in consultation with the Office of the Managing Director, shall determine the proportion of unused funding for use in the Rural Health Care Program in accordance with the public interest to either satisfy demand notwithstanding the annual cap, reduce collections for the Rural Health Care Program, or to hold in reserve to address contingencies for subsequent funding years. The Wireline Competition Bureau shall direct the Administrator to carry out the necessary actions for the use of available funds consistent with the direction specified herein.

**§ 54.620 Annual filing requirements and commitments.**

- (a) *Annual filing requirement.* Health care providers seeking support under the RHC Program shall file new funding requests for each funding year consistent with the filing periods established under this subpart, except for health care providers who have received a multi-year funding commitment under this section.
- (b) *Long-term contracts.* If health care providers enter into long-term contracts for eligible services, the Administrator shall only commit funds to cover the portion of such a long-term contract scheduled to be delivered during the funding year for which universal service support is sought, except for multi-year funding commitments as described in this section.
- (c) *Multi-year commitments under the Healthcare Connect Fund Program.* Participants in the Healthcare Connect Fund Program are permitted to enter into multi-year contracts for eligible expenses and may receive funding commitments from the Administrator for a period that covers up to three years of funding. If a long-term contract covers a period of more than three years, the applicant may also have the contract designated as “evergreen” under § 54.622(i)(3), which will allow the applicant to re-apply for funding under the contract after three years without having to undergo additional competitive bidding.

**§ 54.621 Filing window for requests and prioritization of support.**

- (a) *Filing window for requests.* (1) The Administrator shall open an initial application filing window with an end date no later than 90 days prior to the start of the funding year (i.e., no later than April 1). Prior to announcing the initial opening and closing dates, the Administrator shall seek the approval of the proposed dates from the Chief of the Wireline Competition Bureau.
- (2) The Administrator, after consultation with the Wireline Competition Bureau, may implement such additional filing periods as it deems necessary. To the extent that the Administrator opens an additional filing period, it shall provide notice and include in that notice or soon thereafter the amount of remaining available funding.
- (3) The Administrator shall treat all health care providers filing an application within a filing window period as if their applications were simultaneously received. All funding requests submitted outside of a filing window will not be accepted unless and until the Administrator opens another filing window.
- (b) *Prioritization of support.* The Administrator shall act in accordance with this section when a filing window period for the Telecommunications Program and the Healthcare Connect Fund Program, as described in paragraph (a) of this section, is in effect. When a filing period described in paragraph (a) of this section closes, the Administrator shall calculate the total demand for Telecommunications Program and Healthcare Connect Fund Program support submitted by all applicants during the filing window period. If the total demand during the filing window period

exceeds the total remaining support available for the funding year, then the Administrator shall distribute the available funds consistent with the following priority schedule:

<b>Health Care Provider Site is Located in:</b>	<b>In a Medically Underserved Area/Population (MUA/P)</b>	<b>Not in MUA/P</b>
<i>Extremely Rural Tier</i> (counties entirely outside of a Core Based Statistical Area)	<i>Priority 1</i>	<i>Priority 4</i>
<i>Rural Tier</i> (census tracts within a Core Based Statistical Area that does not have an urban area or urban cluster with a population equal to or greater than 25,000)	<i>Priority 2</i>	<i>Priority 5</i>
<i>Less Rural Tier</i> (census tracts within a Core Based Statistical Area with an urban area or urban cluster with a population equal to or greater than 25,000, but where the census tract does not contain any part of an urban area or urban cluster with population equal to or greater than 25,000)	<i>Priority 3</i>	<i>Priority 6</i>
<i>Non-Rural Tier</i> (all other non-rural areas)	<i>Priority 7</i>	<i>Priority 8</i>

- (1) *Application of prioritization schedule.* The Administrator shall fully fund all eligible requests falling under the first prioritization category before funding requests in the next lower prioritization category. The Administrator shall continue to process all funding requests by prioritization category until there are no available funds remaining. If there is insufficient funding to fully fund all requests in a particular prioritization category, then the Administrator will pro-rate the available funding among all eligible requests in that prioritization category only pursuant to the proration process described in paragraph (b)(2) of this section.
- (2) *Pro-rata reductions.* The Administrator shall act in accordance with this section when a filing window period for the Telecommunications Program and the Healthcare Connect Fund Program, as described in paragraph (a) of this section, is in effect. When a filing window period described in paragraph (a) of this section closes, the Administrator shall calculate the total demand for Telecommunications Program and Healthcare Connect Fund Program support submitted by all applicants during the filing window period. If the total demand during a filing window period exceeds the total remaining support available for the funding year, the Administrator shall take the following steps:
  - (i) The Administrator shall divide the total remaining funds available for the funding year by the demand within the specific prioritization category to produce a pro-rata factor.
  - (ii) The Administrator shall multiply the pro-rata factor by the total dollar amount requested by each applicant in the prioritization category.
  - (iii) The Administrator shall commit funds to each applicant for Telecommunications Program and Healthcare Connect Fund Program support consistent with this calculation.

**§ 54.622 Competitive bidding requirements and exemptions.**

- (a) *Competitive bidding requirement.* All applicants are required to engage in a competitive bidding process for supported services, facilities, or equipment, as applicable, consistent with the requirements set forth in this section and any additional applicable state, Tribal, local, or other procurement requirements, unless they qualify for an exemption listed in paragraph (j) of this section. In addition, applicants may engage in competitive bidding even if they qualify for an exemption. Applicants who utilize a competitive bidding exemption may proceed directly to filing a funding request as described in § 54.623 of this subpart.
- (b) *Fair and open process.* (1) Applicants participating in the Telecommunications Program or Healthcare Connect Fund Program must conduct a fair and open competitive bidding process. The following actions are necessary to satisfy the “fair and open” competitive standard in the Telecommunications Program and the Healthcare Connect Fund Program:
  - (i) All potential bidders and service providers must have access to the same information and must be treated in the same manner throughout the procurement process.
  - (ii) Service providers who intend to bid on supported services may not simultaneously help the applicant complete its request for proposal (RFP) or Request for Services form.
  - (iii) Service providers who have submitted a bid to provide supported services, equipment, or facilities to a health care provider may not simultaneously help the health care provider evaluate submitted bids or choose a winning bid.
  - (iv) Applicants must respond to all service providers that have submitted questions or proposals during the competitive bidding process.
  - (v) All applicants and service providers must comply with any applicable state, Tribal, or local procurement laws, in addition to the Commission’s competitive bidding requirements. The competitive bidding requirements in this section are not intended to preempt such state, Tribal, or local requirements.
- (c) *Selecting a cost-effective service.* In selecting a provider of eligible services, the applicant shall carefully consider all bids submitted and must select the most cost-effective means of meeting its specific health care needs. “Cost-effective” is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services. In the Healthcare Connect Fund Program, when choosing the most “cost-effective” bid, price must be a primary factor, but need not be the only primary factor. A non-price factor may receive an equal weight to price, but may not receive a greater weight than price.
- (d) *Bid evaluation criteria.* Applicants must develop weighted evaluation criteria (e.g., a scoring matrix) that demonstrates how the applicant will choose the most cost-effective bid before submitting its request for services. The applicant must specify on its bid evaluation worksheet and/or scoring matrix the requested services for which it seeks bids, the information provided to bidders to allow bidders to reasonably determine the needs of the applicant, its minimum requirements for the developed weighted evaluation criteria, and each service provider’s proposed service levels for the criteria. The applicant must also specify the disqualification factors, if any, that it will use to remove bids or bidders from further consideration. After reviewing the bid submissions and identifying the bids that satisfy the applicant’s specific needs, the applicant must then select the service provider that offers the most cost-effective service.
- (e) *Request for Services.* Applicants must submit the following documents to the Administrator in order to initiate competitive bidding:
  - (1) *Request for Services, including certifications.* The applicant must submit a Request for Services and make the following certifications as part of its Request for Services:



- (i) The health care provider seeking supported services is a public or nonprofit entity that falls within one of the seven categories set forth in the definition of health care provider, listed in §54.600 of this subpart.
- (ii) The health care provider seeking supported services is physically located in a rural area as defined in § 54.600 of this subpart, or is a member of a Healthcare Connect Fund Program consortium which satisfies the rural health care provider composition requirements set forth in § 54.607(b) of this subpart.
- (iii) The person signing the application is authorized to submit the application on behalf of the health care provider or consortium applicant.
- (iv) The person signing the application has examined the Request for Services and all attachments, and to the best of his or her knowledge, information, and belief, all statements contained in the request are true.
- (v) The applicant has complied with any applicable state, Tribal, or local procurement rules.
- (vi) All requested Rural Health Care Program support will be used solely for purposes reasonably related to the provision of health care service or instruction that the health care provider is legally authorized to provide under the law of the state in which the services are provided.
- (vii) The supported services will not be sold, resold, or transferred in consideration for money or any other thing of value.
- (viii) The applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules.
- (ix) The applicant has reviewed all applicable requirements for the Telecommunications Program or the Healthcare Connect Fund Program, as applicable, and will comply with those requirements.
- (x) *Additional certification for the Telecom Program.* Telecom Program applicants must certify that the rural rate on their Request for Funding does not exceed the appropriate rural rate determined by the Administrator.
- (2) *Aggregated purchase details.* If the service or services are being purchased as part of an aggregated purchase with other entities or individuals, the full details of any such arrangement, including the identities of all co-purchasers and the portion of the service or services being purchased by the health care provider, must be submitted.
- (3) *Bid evaluation criteria.* Requirements for bid evaluation criteria are described in paragraph (d) of this section and must be included with the applicant's Request for Services.
- (4) *Declaration of Assistance.* All applicants must submit a "Declaration of Assistance" with their Request for Services. In the Declaration of Assistance, the applicant must identify each and every consultant, service provider, and other outside expert, whether paid or unpaid, who aided in the preparation of its applications. The applicant must also describe the nature of the relationship it has with each consultant, service provider, or other outside expert providing such assistance.
- (5) *Request for proposal (if applicable).* (i) Any applicant may use an RFP. Applicants who use an RFP must submit the RFP and any additional relevant bidding information to the Administrator with its Request for Services.
  - (i) An applicant must submit an RFP:
    - (A) If it is required to issue an RFP under applicable State, Tribal, or local procurement rules or regulations;
    - (B) If the applicant is a consortium seeking more than \$100,000 in program support during the funding year, including applications that seek more than \$100,000 in program support for a multi-year commitment; or

(C) If the applicant is a consortium seeking support for participant-constructed and owned network facilities.

(ii) RFP requirements.

(A) An RFP must provide sufficient information to enable an effective competitive bidding process, including describing the health care provider's service needs and defining the scope of the project and network costs (if applicable).

(B) An RFP must specify the time period during which bids will be accepted.

(C) An RFP must include the bid evaluation criteria described in paragraph (d) of this section, and solicit sufficient information so that the criteria can be applied effectively.

(D) Consortium applicants seeking support for long-term capital investments whose useful life extends beyond the time period of the funding commitment (e.g., facilities constructed and owned by the applicant, fiber indefeasible rights of use) must seek bids in the same RFP from service providers who propose to meet those needs via services provided over service provider-owned facilities, for a time period comparable to the life of the proposed capital investment.

(E) Applicants may prepare RFPs in any manner that complies with the rules in this subpart and any applicable state, Tribal, or local procurement rules or regulations.

(6) *Additional requirements for Healthcare Connect Fund Program consortium applicants.*

(i) *Network plan.* Consortium applicants must submit a narrative describing specific elements of their network plan with their Request for Services. Consortia applicants are required to use program support for the purposes described in their narrative. The required elements of the narrative include:

(A) Goals and objectives of the network;

(B) Strategy for aggregating the specific needs of health care providers (including providers that serve rural areas) within a state or region;

(C) Strategy for leveraging existing technology to adopt the most efficient and cost-effective means of connecting those providers;

(D) How the supported network will be used to improve or provide health care delivery;

(E) Any previous experience in developing and managing health information technology (including telemedicine) programs; and

(F) A project management plan outlining the project's leadership and management structure, and a work plan, schedule, and budget.

(ii) *Letters of agency (LOA).* Consortium applicants must submit LOAs pursuant to §54.610.

(f) *Public posting by the Administrator.* The Administrator shall post on its website the following competitive bidding documents, as applicable:

(1) Request for Services,

(2) Bid evaluation criteria,

(3) RFP, and

(4) Network plans for Healthcare Connect Fund Program applicants.

(g) *28-day waiting period.* After posting the documents described in paragraph (f) of this section, as applicable, on its website, the Administrator shall send confirmation of the posting to the applicant. The applicant shall wait at least 28 days from the date on which its competitive bidding documents are posted on the Administrator's website before selecting and committing to a service

provider. The confirmation from the Administrator shall include the date after which the applicant may sign a contract with its chosen service provider(s).

- (1) *Selection of the most “cost-effective” bid and contract negotiation.* Each applicant is required to certify to the Administrator that the selected bid is, to the best of the applicant’s knowledge, the most cost-effective option available. Applicants are required to submit the documentation, identified in § 54.623 of this subpart, to support their certifications.
- (2) Applicants who plan to request evergreen status under this section must enter into a contract that identifies both parties, is signed and dated by the health care provider or Consortium Leader after the 28-day waiting period expires, and specifies the type, term, and cost of service(s).
- (h) *Gift restrictions.* (1) Subject to paragraphs (h)(3) and (h)(4) of this section, an eligible health care provider or consortium that includes eligible health care providers, may not directly or indirectly solicit or accept any gift, gratuity, favor, entertainment, loan, or any other thing of value from a service provider participating in or seeking to participate in the Rural Health Care Program. No such service provider shall offer or provide any such gift, gratuity, favor, entertainment, loan, or other thing of value except as otherwise provided herein. Modest refreshments not offered as part of a meal, items with little intrinsic value intended solely for presentation, and items worth \$20 or less, including meals, may be offered or provided, and accepted by any individual or entity subject to this rule, if the value of these items received by any individual does not exceed \$50 from any one service provider per funding year. The \$50 amount for any service provider shall be calculated as the aggregate value of all gifts provided during a funding year by the individuals specified in paragraph (h)(2)(ii) of this section.
- (2) For purposes of this paragraph:
  - (i) The terms “health care provider” or “consortium” shall include all individuals who are on the governing boards of such entities and all employees, officers, representatives, agents, consultants, or independent contractors of such entities involved on behalf of such health care provider or consortium with the Rural Health Care Program, including individuals who prepare, approve, sign, or submit Rural Health Care Program applications, or other forms related to the Rural Health Care Program, or who prepare bids, communicate, or work with Rural Health Care Program service providers, consultants, or with the Administrator, as well as any staff of such entities responsible for monitoring compliance with the Rural Health Care Program; and
  - (ii) The term “service provider” includes all individuals who are on the governing boards of such an entity (such as members of the board of directors), and all employees, officers, representatives, agents, consultants, or independent contractors of such entities.
- (3) The restrictions set forth in this paragraph shall not be applicable to the provision of any gift, gratuity, favor, entertainment, loan, or any other thing of value, to the extent given to a family member or a friend working for an eligible health care provider or consortium that includes eligible health care providers, provided that such transactions:
  - (i) Are motivated solely by a personal relationship;
  - (ii) Are not rooted in any service provider business activities or any other business relationship with any such eligible health care provider; and
  - (iii) Are provided using only the donor’s personal funds that will not be reimbursed through any employment or business relationship.
- (4) Any service provider may make charitable donations to an eligible health care provider or consortium that includes eligible health care providers in the support of its programs as long as such contributions are not directly or indirectly related to the Rural Health Care Program procurement activities or decisions and are not given by service providers to circumvent competitive bidding and other Rural Health Care Program rules, including those in § 54.611 of

this subpart, requiring health care providers under the Healthcare Connect Fund Program to contribute 35 percent of the total cost of all eligible expenses.

- (i) *Exemptions to the competitive bidding requirements.*
- (1) *Government Master Service Agreement (MSA).* Eligible health care providers that seek support for services and equipment purchased from MSAs negotiated by federal, state, Tribal, or local government entities on behalf of such health care providers and others, if such MSAs were awarded pursuant to applicable federal, state, Tribal, or local competitive bidding requirements, are exempt from the competitive bidding requirements under this section.
- (2) *Master Service Agreements approved under the Rural Health Care Pilot Program or Healthcare Connect Fund Program.* An eligible health care provider site may opt into an existing MSA approved under the Rural Health Care Pilot Program or Healthcare Connect Fund Program and seek support for services and equipment purchased from the MSA without triggering the competitive bidding requirements under this section, if the MSA was developed and negotiated in response to an RFP that specifically solicited proposals that included a mechanism for adding additional sites to the MSA.
- (3) *Evergreen contracts.*
  - (i) The Administrator may designate a multi-year contract as “evergreen,” which means that the service(s) covered by the contract need not be re-bid during the contract term.
  - (ii) A contract entered into by a health care provider or consortium as a result of competitive bidding may be designated as evergreen if it meets all of the following requirements:
    - (A) Is signed by the individual health care provider or consortium lead entity;
    - (B) Specifies the service type, bandwidth, and quantity;
    - (C) Specifies the term of the contract;
    - (D) Specifies the cost of services to be provided; and
    - (E) Includes the physical location or other identifying information of the health care provider sites purchasing from the contract.
  - (iii) Participants may exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding if:
    - (A) The voluntary extension(s) is memorialized in the evergreen contract;
    - (B) The decision to extend the contract occurs before the participant files its funding request for the funding year when the contract would otherwise expire; and
    - (C) The voluntary extension(s) do not exceed five years in the aggregate.
- (4) *Schools and libraries program master contracts.* Subject to the provisions in §§ 54.500, 54.501(c)(1), and 54.503 of subpart H, an eligible health care provider in a consortium with participants in the Schools and Libraries Universal Service Support Program and a party to the consortium’s existing contract is exempt from the competitive bidding requirements if the contract was approved in the Schools and Libraries Universal Service Support Program as a master contract. The health care provider must comply with all Rural Health Care Program rules and procedures except for those applicable to competitive bidding.
- (5) *Annual undiscounted cost of \$10,000 or less.* An applicant under the Healthcare Connect Fund Program that seeks support for \$10,000 or less of total undiscounted eligible expenses for a single year is exempt from the competitive bidding requirements under this section, if the term of the contract is one year or less. This exemption does not apply to applicants under the Telecommunications Program.

**§ 54.623 Request for funding.**

- (a) Once a service provider is selected, applicants must submit a Request for Funding (and supporting documentation) to provide information about the services, equipment, or facilities selected; rates, service provider(s); and date(s) of service provider selection, as applicable.
- (1) *Certifications.* The applicant must provide the following certifications as part of its Request for Funding:
  - (i) The person signing the application is authorized to submit the application on behalf of the health care provider or consortium.
  - (ii) The applicant has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.
  - (iii) The health care provider or consortium has considered all bids received and selected the most cost-effective method of providing the requested services.
  - (iv) All Rural Health Care Program support will be used only for eligible health care purposes.
  - (v) The health care provider or consortium is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund Program.
  - (vi) The health care provider or consortium and/or its consultant, if applicable, has not solicited or accepted a gift or any other thing of value from a service provider participating in or seeking to participate in the Rural Health Care Program.
  - (vii) The applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules and understands that any letter from the Administrator that erroneously commits funds for the benefit of the applicant may be subject to rescission.
  - (viii) The applicant has reviewed all applicable rules and requirements for the Rural Health Care Program and will comply with those rules and requirements.
  - (ix) The applicant will retain all documentation associated with the applications, including all bids, contracts, scoring matrices, and other information associated with the competitive bidding process, and all billing records for services received, for a period of at least five years.
  - (x) The consultants or third parties hired by the applicant do not have an ownership interest, sales commission arrangement, or other financial stake in the service provider chosen to provide the requested services, and that they have otherwise complied with the Rural Health Care Program rules, including the Commission's rules requiring a fair and open competitive bidding process.
- (2) *Contracts or other documentation.* All applicants must submit a contract or other documentation, as applicable, that clearly identifies the service provider(s) selected and the health care provider(s) who will receive the services; costs for which support is being requested; and the term of the service agreement(s) if applicable (i.e., if services are not being provided on a month-to-month basis). For services provided under contract, the applicant must submit a copy of the contract signed and dated (after the Allowable Contract Selection Date) by the individual health care provider or Consortium Leader. If the services are not being provided under contract, the applicant must submit a bill, service offer, letter, or similar document from the service provider that provides the required information.
- (3) *Competitive bidding documents.* Applicants must submit documentation to support their certifications that they have selected the most cost-effective option, including a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and the following documents (as applicable): completed bid evaluation worksheets or matrices; explanation for any disqualified bids; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the service provider selection/award; copies of notices to winners; and any correspondence with service



providers prior to and during the bidding, evaluation, and award phase of the process. Applicants who claim a competitive bidding exemption must submit relevant documentation to allow the Administrator to verify that the applicant is eligible for the claimed exemption.

- (4) *Cost allocation for ineligible entities or components.* Where applicable, applicants must submit a description of how costs will be allocated for ineligible entities or components, as well as any agreements that memorialize such arrangements with ineligible entities.
- (5) *Additional documentation for Healthcare Connect Fund Program consortium applicants.* A consortium applicant must also submit the following:
  - (i) Any revisions to the network plan submitted with the Request for Services pursuant to §54.622, as necessary. If not previously submitted, the consortium should provide a narrative description of how the network will be managed, including all administrative aspects of the network, including, but not limited to, invoicing, contractual matters, and network operations. If the consortium is required to provide a sustainability plan as set forth below, the revised budget should include the budgetary factors discussed in the sustainability plan requirements.
  - (ii) A list of each participating health care provider and all of their relevant information, including eligible (and ineligible, if applicable) cost information.
  - (iii) Evidence of a viable source for the undiscounted portion of supported costs.
  - (iv) Sustainability plans for applicants requesting support for long-term capital expenses: Consortia that seek funding to construct and own their own facilities or obtain indefeasible right of use or capital lease interests are required to submit a sustainability plan with their funding requests demonstrating how they intend to maintain and operate the facilities that are supported over the relevant time period. Applicants may incorporate by reference other portions of their applications (e.g., project management plan, budget). The sustainability plan must, at a minimum, address the following points:
    - (A) *Projected sustainability period.* Indicate the sustainability period, which at a minimum is equal to the useful life of the funded facility. The consortium's budget must show projected income and expenses (i.e., for maintenance) for the project at the aggregate level, for the sustainability period.
    - (B) *Principal factors.* Discuss each of the principal factors that were considered by the participant to demonstrate sustainability. This discussion must include all factors that show that the proposed network will be sustainable for the entire sustainability period. Any factor that will have a monetary impact on the network must be reflected in the applicant's budget.
    - (C) *Terms of membership in the network.* Describe generally any agreements made (or to be entered into) by network members (e.g., participation agreements, memoranda of understanding, usage agreements, or other similar agreements). The sustainability plan must also describe, as applicable:
      - (1) Financial and time commitments made by proposed members of the network;
      - (2) If the project includes excess bandwidth for growth of the network, describe how such excess bandwidth will be financed; and
      - (3) If the network will include ineligible health care providers and other network members, describe how fees for joining and using the network will be assessed.
    - (D) *Ownership structure.* Explain who will own each material element of the network (e.g., fiber constructed, network equipment, end user equipment). For purposes of this subsection, "ownership" includes an indefeasible right of use interest. Applicants must clearly identify the legal entity that will own each material element. Applicants must also describe any arrangements made to ensure continued use of such elements by the network members for the duration of the sustainability period.

- (E) *Sources of future support.* Describe other sources of future funding, including fees to be paid by eligible health care providers and/or non-eligible entities.
- (F) *Management.* Describe the management structure of the network for the duration of the sustainability period. The applicant's budget must describe how management costs will be funded.
- (v) *Material change to sustainability plan.* A consortium that is required to file a sustainability plan must maintain its accuracy. If there is a material change to a required sustainability plan that would impact projected income or expenses by more than 20 percent or \$100,000 from the previous submission, or if the applicant submits a funding request based on a new Request for Funding (i.e., a new competitively bid contract), the consortium is required to re-file its sustainability plan. In the event of a material change, the applicant must provide the Administrator with the revised sustainability plan no later than the end of the relevant quarter, clearly showing (i.e., by redlining or highlighting) what has changed.

**§ 54.624 Site and service substitutions.**

- (a) Health care providers or Consortium Leaders may request a site or service substitution if:
  - (1) The substitution is provided for in the contract, within the change clause, or constitutes a minor modification;
  - (2) The site is an eligible health care provider and the service is an eligible service under the Telecommunications Program or the Healthcare Connect Fund Program;
  - (3) The substitution does not violate any contract provision or state, Tribal, or local procurement laws; and
  - (4) The requested change is within the scope of the controlling Request for Services, including any applicable RFP used in the competitive bidding process.
- (b) *Filing deadline.* An applicant must file their request for a site or service change to the Administrator no later than the service delivery deadline as defined in § 54.626.

**§ 54.625 Service Provider Identification Number (SPIN) changes.**

- (a) *Corrective SPIN change.* A "corrective SPIN change" is any amendment to the SPIN associated with a Funding Request Number that does not involve a change to the service provider associated with that Funding Request Number. An applicant under the Telecommunications Program or the Healthcare Connect Fund Program may file a request for a corrective SPIN change with the Administrator to:
  - (1) Correct ministerial errors;
  - (2) Update the service provider's SPIN that resulted from a merger or acquisition of companies; or
  - (3) Effectuate a change to the SPIN that does not involve a change to the service provider of a funding request and was not initiated by the applicant.
- (b) *Operational SPIN Change.* An "operational SPIN change" is any change to the service provider associated with a Funding Request Number. An applicant under the Telecommunications Program or the Healthcare Connect Fund Program may file a request for an operational SPIN change with the Administrator if:
  - (1) The applicant has a legitimate reason to change providers (e.g., breach of contract or the service provider is unable to perform); and
  - (2) The applicant's newly selected service provider received the next highest point value in the original bid evaluation, assuming there were multiple bidders.

- (c) *Filing deadline.* An applicant must file their request for a corrective or operational SPIN change with the Administrator no later than the service delivery deadline as defined by section 54.626.

**§ 54.626 Service delivery deadline and extension requests.**

- (a) *Service delivery deadline.* Except as provided below, applicants must use all recurring and non-recurring services for which Telecommunications Program and Healthcare Connect Fund Program funding has been approved by June 30 of the funding year for which the program support was sought. The Administrator will deem ineligible for Telecommunications Program and Healthcare Connect Fund Program support all charges incurred for services delivered before or after the close of the funding year.
- (b) *Deadline extension for non-recurring services.* An applicant may request and receive from the Administrator a one-year extension of the implementation deadline for non-recurring services if it satisfies one of the following criteria:
- (1) Applicants whose funding commitment letters are issued by the Administrator on or after March 1 of the funding year for which discounts are authorized;
  - (2) Applicants that receive service provider change authorizations or site and service authorizations from the Administrator on or after March 1 of the funding year for which discounts are authorized;
  - (3) Applicants whose service providers are unable to complete implementation for reasons beyond the service provider's control; or
  - (4) Applicants whose service providers are unwilling to complete delivery and installation because the applicant's funding request is under review by the Administrator for program compliance.

*Note to Paragraphs (b)(1) and (b)(2):* The Administrator shall automatically extend the service delivery deadline for applicants who satisfy paragraphs (b)(1) or (b)(2) of this section. When calculating the extended deadline, March 1 is the key date for determining whether to extend the service delivery deadline. If one of the conditions listed in paragraph (b) of this section is satisfied before March 1 (of any year), the deadline will not be extended and the applicant will have until June 30 of that calendar year to complete implementation. If one of the conditions under paragraph (b)(1)-(2) of this section is satisfied on or after March 1 the calendar year, the applicant will have until June 30 of the following calendar year to complete implementation.

*Note to Paragraph (b)(3):* An applicant seeking a one-year extension must affirmatively request an extension on or before the June 30 deadline for paragraph (b)(3) of this section. The Administrator will address any situations arising under paragraph (b)(3) of this section on a case-by-case basis. Applicants must submit documentation to the Administrator requesting relief pursuant to paragraph (b)(3) on or before June 30 of the relevant funding year. That documentation must include, at a minimum, an explanation regarding the circumstances that make it impossible for installation to be completed by June 30 and a certification by the applicant that, to the best of their knowledge, the request is truthful.

*Note to Paragraph (b)(4):* An applicant seeking a one-year extension must affirmatively request an extension on or before the June 30 deadline for paragraph (b)(4) of this section. Applicants seeking an extension under paragraph (b)(4) must certify to the Administrator that their service provider was unwilling to deliver or install the non-recurring services before the end of the funding year. Applicants must make this certification on or before June 30 of the relevant funding year. The revised implementation date will be calculated based on the date the Administrator issues a funding commitment.

**§ 54.627 Invoicing process and certifications.**

- (a) *Invoice filing deadline.* Invoices must be submitted to the Administrator within 120 days after the later of: (1) the service delivery deadline, as defined in section 54.626 of this subpart; or (2) the

date of a revised funding commitment letter issued pursuant to an approved post-commitment request made by the applicant or service provider or a successful appeal of a previously denied or reduced funding request. Before the Administrator may process and pay an invoice, it must receive a completed invoice from the service provider.

- (b) *Invoice deadline extension.* Service providers or billed entities may request a one-time extension of the invoicing deadline by no later than the deadline calculated pursuant to paragraph (a) of this section. The Administrator shall grant a 120-day extension of the invoice filing deadline, if it is timely requested.
- (c) *Telecommunications Program.* (1) The applicant must submit documentation to the Administrator confirming the service start date, the service end or disconnect date, or whether the service was never turned on.
  - (2) Upon receipt of the invoice(s) and supporting documentation, the Administrator shall generate a Health Care Provider Support Schedule (HSS), which the service provider shall use to determine how much credit the applicant will receive for the services.
  - (3) *Certifications.* Before the Administrator may process and pay an invoice, both the health care provider and the service provider must make the following certifications.
    - (i) The health care provider must certify that:
      - (A) The service has been or is being provided to the above-named health care provider;
      - (B) The universal service credit will be applied to the telecommunications service billing account of the health care provider or the billed entity as directed by the health care provider;
      - (C) It is authorized to submit this request on behalf of the above-named health care provider;
      - (D) It has examined the invoice and supporting documentation and that to the best of its knowledge, information and belief, all statements of fact contained herein are true;
      - (E) It or the consortium it represents satisfies all of the requirements and will abide by all of the relevant requirements, including all applicable Commission rules, with respect to universal service benefits provided under 47 U.S.C. § 254; and
      - (F) It understands that any letter from the Administrator that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.
    - (ii) The service provider must certify that:
      - (A) The information contained in the invoice is correct and the health care providers and the Billed Account Numbers listed above have been credited with the amounts shown under “Support Amount to be Paid by USAC;”
      - (B) It has abided by all of the relevant requirements, including all applicable Commission rules;
      - (C) It has received and reviewed the HSS, invoice form and accompanying documentation, and that the rates charged for the telecommunications services, to the best of its knowledge, information and belief, are accurate and comply with the Commission’s rules;
      - (D) It is authorized to submit the invoice;
      - (E) The health care provider paid the appropriate urban rate for the telecommunications services;
      - (F) The rural rate on the invoice does not exceed the appropriate rural rate determined by the Administrator;
      - (G) It has charged the health care provider for only eligible services prior to submitting the invoice for payment and accompanying documentation;

- (H) It has not offered or provided a gift or any other thing of value to the applicant (or to the applicant's personnel, including its consultant) for which it will provide services; and
- (I) The consultants or third parties it has hired do not have an ownership interest, sales commission arrangement, or other financial stake in the service provider chosen to provide the requested services, and that they have otherwise complied with Rural Health Care Program rules, including the Commission's rules requiring fair and open competitive bidding.
- (J) As a condition of receiving support, it will provide to the health care providers, on a timely basis, all documents regarding supported equipment or services that are necessary for the health care provider to submit required forms or respond to Commission or Administrator inquiries.
- (d) *Healthcare Connect Fund Program. (1) Certifications.* Before the Administrator may process and pay an invoice, the Consortium Leader (or health care provider, if participating individually) and the service provider must make the following certifications:
  - (i) The Consortium Leader or health care provider must certify that:
    - (A) It is authorized to submit this request on behalf of the health care provider or consortium;
    - (B) It has examined the invoice form and attachments and, to the best of its knowledge, information, and belief, all information contained therein is true and correct;
    - (C) The health care provider or consortium members have received the related services, network equipment, and/or facilities itemized on the invoice form; and
    - (D) The required 35 percent minimum contribution for each item on the invoice form was funded by eligible sources as defined in the Commission's rules and that the required contribution was remitted to the service provider.
  - (ii) The service provider must certify that:
    - (A) It has been authorized to submit this request on behalf of the service provider;
    - (B) It has applied the amount submitted, approved, and paid by the Administrator to the billing account of the health care provider(s) and Funding Request Number (FRN)/FRN ID listed on the invoice;
    - (C) It has examined the invoice form and attachments and that, to the best of its knowledge, information, and belief, the date, quantities, and costs provided in the invoice form and attachments are true and correct;
    - (D) It has abided by all program requirements, including all applicable Commission rules and orders;
    - (E) It has charged the health care provider for only eligible services prior to submitting the invoice form and accompanying documentation;
    - (F) It has not offered or provided a gift or any other thing of value to the applicant (or to the applicant's personnel, including its consultant) for which it will provide services;
    - (G) The consultants or third parties it has hired do not have an ownership interest, sales commission arrangement, or other financial stake in the service provider chosen to provide the requested services, and that they have otherwise complied with Rural Health Care Program rules, including the Commission's rules requiring fair and open competitive bidding; and
  - (H) As a condition of receiving support, it will provide to the health care providers, on a timely basis, all documents regarding supported equipment, facilities, or services that are necessary for the health care provider to submit required forms or respond to Commission or Administrator inquiries.



**§ 54.628 Duplicate support.**

- (a) Eligible health care providers that seek support under the Healthcare Connect Fund Program for telecommunications services may not also request support from the Telecommunications Program for the same services.
- (b) Eligible health care providers that seek support under the Telecommunications Program or the Healthcare Connect Fund Program may not also request support from any other universal service program for the same expenses.

**§ 54.629 Prohibition on resale.**

- (a) *Prohibition on resale.* Services purchased pursuant to universal support mechanisms under this subpart shall not be sold, resold, or transferred in consideration for money or any other thing of value.
- (b) *Permissible fees.* The prohibition on resale set forth in paragraph (a) of this section shall not prohibit a health care provider from charging normal fees for health care services, including instruction related to services purchased with support provided under this subpart.

**§ 54.630 Election to offset support against annual universal service fund contribution.**

- (a) A service provider that contributes to the universal service support mechanisms under this subpart and subpart H of this part to eligible health care providers may, at the election of the contributor:
  - (1) Treat the amount eligible for support under this subpart as an offset against the contributor's universal service support obligation for the year in which the costs for providing eligible services were incurred; or
  - (2) Receive direct reimbursement from the Administrator for that amount.
- (b) Service providers that are contributors shall elect in January of each year the method by which they will be reimbursed and shall remain subject to that method for the duration of the calendar year. Any support amount that is owed a service provider that fails to remit its monthly universal service contribution obligation shall first be applied as an offset to that contributor's contribution obligation. Such a service provider shall remain subject to the offsetting method for the remainder of the calendar year in which it failed to remit its monthly universal service obligation. A service provider that continues to be in arrears on its universal service contribution obligations at the end of a calendar year shall remain subject to the offsetting method for the next calendar year.
- (c) If a service provider providing services eligible for support under this subpart elects to treat that support amount as an offset against its universal service contribution obligation and the total amount of support owed exceeds its universal service obligation, calculated on an annual basis, the service provider shall receive a direct reimbursement in the amount of the difference. Any such reimbursement due a service provider shall be provided by the Administrator no later than the end of the first quarter of the calendar year following the year in which the costs were incurred and the offset against the contributor's universal service obligation was applied.

**§ 54.631 Audits and recordkeeping.**

- (a) *Random audits.* All participants under the Telecommunications Program and Healthcare Connect Fund Program shall be subject to random compliance audits to ensure compliance with program rules and orders.
- (b) *Recordkeeping.* Participants, including Consortium Leaders and health care providers, shall maintain records to document compliance with program rules and orders for at least five years after the last day of service delivered in a particular funding year sufficient to establish compliance with all rules in this subpart.

- (1) *Telecommunications Program.* (i) Participants must maintain, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities, if applicable.
  - (ii) Mobile rural health care providers shall maintain annual logs for a period of five years. Mobile rural health care providers shall maintain annual logs indicating: the date and locations of each clinical stop; and the number of patients served at each clinical stop. Mobile rural health care providers shall make their logs available to the Administrator and the Commission upon request.
  - (iii) Service providers shall retain documents related to the delivery of discounted services for at least five years after the last day of the delivery of discounted services. Any other document that demonstrates compliance with the statutory or regulatory requirements for the rural health care mechanism shall be retained as well.
- (2) *Healthcare Connect Fund Program.* (i) Participants who receive support for long-term capital investments in facilities whose useful life extends beyond the period of the funding commitment shall maintain records for at least five years after the end of the useful life of the facility. Participants shall maintain asset and inventory records of supported network equipment to verify the actual location of such equipment for a period of five years after purchase.
  - (ii) Service providers shall retain records related to the delivery of supported services, facilities, or equipment to document compliance with the Commission rules or orders pertaining to the Healthcare Connect Fund Program for at least five years after the last day of the delivery of supported services, equipment, or facilities in a particular funding year.
  - (c) *Production of records.* Both participants and service providers under the Telecommunications Program and Healthcare Connect Fund Program shall produce such records at the request of the Commission, any auditor appointed by the Administrator or Commission, or any other state or federal agency with jurisdiction.
  - (d) *Obligation of service providers.* Service providers in the Telecommunications Program and Healthcare Connect Fund Program must certify, as a condition of receiving support, that they will provide to health care providers, on a timely basis, all information and documents regarding supported equipment, facilities, or services that are necessary for the health care provider to submit required forms or respond to Commission or Administrator inquiries. The Administrator may withhold disbursements for the service provider if the service provider, after written notice from the Administrator, fails to comply with this requirement.

**§ 54.632 Signature requirements for certifications.**

- (a) For individual health care provider applicants, required certifications must be provided and signed by an officer or director of the health care provider, or other authorized employee of the health care provider.
- (b) For consortium applicants, an officer, director, or other authorized employee of the Consortium Leader must sign the required certifications.
- (c) Pursuant to § 54.633, electronic signatures are permitted for all required certifications.

**§ 54.633 Validity of electronic signatures and records.**

- (a) For the purposes of this subpart, an electronic signature (defined by the Electronic Signatures in Global and National Commerce Act, as an electronic sound, symbol, or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record) has the same legal effect as a written signature.
- (b) For the purposes of this subpart, an electronic record (defined by the Electronic Signatures in Global and National Commerce Act, as a contract or other record created, generated, sent, communicated, received, or stored by electronic means) constitutes a record.

## APPENDIX B

## Final Regulatory Flexibility Analysis

1. As required by the Regulatory Flexibility Act of 1980 (RFA),<sup>1</sup> as amended, the Federal Communications Commission (Commission) included an Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in the *2017 Promoting Telehealth Notice and Order* in WC Docket No. 17-310.<sup>2</sup> The Commission sought written public comment on the proposals in the *2017 Promoting Telehealth Notice and Order*, including comment on the IRFA. The Commission did not receive any relevant comments in response to this IRFA. This Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.<sup>3</sup>

**A. Need for, and Objectives of, the Report and Order**

2. Section 254(h)(1)(A) of the Telecommunications Act of 1996 (1996 Act) mandates that telecommunications carriers provide telecommunications services for health care purposes to eligible rural public or non-profit health care providers at rates that are “reasonably comparable” to rates in urban areas.<sup>4</sup> In addition, section 254(h)(2)(A) of the 1996 Act directs the Commission to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to “advanced telecommunications and information services” for public and non-profit health care providers.<sup>5</sup> Based on this legislative mandate, the Commission established the two components of the Rural Health Care (RHC) Program—the Telecommunications (Telecom) Program and the Healthcare Connect Fund Program. The Telecom Program subsidizes the difference between urban and rural rates for telecommunications services.<sup>6</sup> Eligible rural health care providers can obtain rates on telecommunications services for their rural health care facilities that are reasonably comparable to rates charged for similar services in corresponding urban areas.<sup>7</sup> The Telecom Program has not undergone any significant change since its creation more than two decades ago. The Healthcare Connect Fund Program, created in 2012, provides a flat 65% discount on an array of advanced telecommunications and information services.<sup>8</sup> These services include Internet access, dark fiber, business data, traditional Digital Subscriber Line (DSL), and private carriage services.<sup>9</sup> With the Healthcare Connect Fund Program, the Commission intended to promote the use of broadband services and facilitate the formation of health care provider consortia.<sup>10</sup>

<sup>1</sup> 5 U.S.C. § 603. The RFA, 5 U.S.C. §§ 601-612, has been amended by the Contract with America Advancement Act of 1996, Public Law No. 104-121, 110 Stat. 847 (1996) (CWAAA). Title II of the CWAAA is the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA).

<sup>2</sup> See *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631 (2017) (*2017 Promoting Telehealth Notice and Order*).

<sup>3</sup> See 5 U.S.C. § 604.

<sup>4</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>5</sup> 47 U.S.C. § 254(h)(2)(A).

<sup>6</sup> See 47 U.S.C. § 254(h)(1)(A); See *Universal Service First Report and Order*, 12 FCC Rcd 8776, 9093-9161, paras. 608-749 (1997) (*Universal Service First Report and Order*).

<sup>7</sup> See 47 U.S.C. § 254(h)(1)(A); *Universal Service First Report and Order*, 12 FCC Rcd at 9093-9161, paras. 608-749.

<sup>8</sup> See 47 U.S.C. § 254(h)(2)(A); 47 CFR § 54.633; *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16680-81, paras. 1-3 (2012) (*Healthcare Connect Fund Order*).

<sup>9</sup> See 47 CFR § 54.634.

<sup>10</sup> See *Healthcare Connect Fund Order*, 27 FCC Rcd at 16678, para. 1.

3. Demand for RHC Program funding has rapidly increased over the past few years. As the demand for robust broadband has increased throughout the country, the RHC Program has witnessed a dramatic increase in health care provider participation. This recent increase in RHC Program demand necessitates a re-evaluation of the RHC Program rules and procedures to promote the efficient allocation of limited funds and provide predictability and transparency for the RHC Program. In 2018, the Commission raised the annual funding cap to \$571 million, adjusted annually for inflation.<sup>11</sup> The Commission cannot simply keep raising the cap to meet rising demand without first taking a hard look at reforming the current process to further the efficient allocation of limited resources. To this end, in December 2017, the Commission released the *2017 Promoting Telehealth Notice and Order* seeking comment on various ways to improve the RHC Program.<sup>12</sup> Specifically, the Commission sought comment on whether and how to reform the calculation of urban and rural rates used to determine the amount of support available to health care providers under the Telecom Program.<sup>13</sup> The Commission also sought comment on whether and how to prioritize RHC Program funding when demand exceeds the cap to ensure limited support is better targeted to rural and Tribal health care providers.<sup>14</sup> Additionally, the Commission sought comment on the rules concerning the appropriate percentage of rural versus non-rural health care providers in Healthcare Connect Fund Program consortia; various actions to prevent waste, fraud, and abuse in the RHC Program; and how to better align procedures between the Telecom and Healthcare Connect Fund Programs.<sup>15</sup>

4. In this Report and Order, the Commission implements a number of the proposals in the *2017 Promoting Telehealth Notice and Order* to improve the RHC Program. First, the Commission reforms the Telecom Program to more efficiently distribute RHC Program funding and minimize the potential for waste, fraud, and abuse in the program in order to better maximize RHC Program funding. Second, the Commission takes several actions to target and prioritize funding to those rural areas in the most need of health care services and ensure that eligible rural health care providers continue to benefit from RHC Program funding. Third, the Commission implements a variety of measures directed at strengthening the competitive bidding requirements under the RHC Program to ensure that program participants comply with the RHC Program rules and procedures, and improve uniformity and transparency across the RHC Program. Fourth, the Commission adopts a series of program-wide rules and procedures, applying both to the Telecom and Healthcare Connect Fund Programs, intended to simplify the application process for program participants and provide more clarity regarding the RHC Program procedures. Lastly, the Commission directs the Universal Service Administrative Company (the Administrator), the administrator of the universal service programs, to take a variety of actions to simplify the RHC Program's applications process, increase transparency in the RHC Program, and ensure that all applicants receive complete and timely information to help inform their decisions regarding RHC eligible services and purchases. improve the application and data collection processes and more effectively manage the RHC Program. The Commission believes that these changes, taken together, will increase the ability of health care providers to better utilize telecommunications and broadband services to meet the health care needs in their communities, and will ensure that RHC Program dollars are serving their intended purpose.

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<sup>11</sup> See 47 CFR § 54.675(a)(1); *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 33 FCC Rcd 6574, 6584, para. 23 (2018).

<sup>12</sup> See generally *2017 Promoting Telehealth Notice and Order*, 32 FCC Rcd 10631.

<sup>13</sup> *Id.* at 10651-55, paras. 60-72.

<sup>14</sup> *Id.* at 10643-45, paras. 21-34.

<sup>15</sup> *Id.* at 10646, paras. 37-39, 10658-67, paras. 85-106.

**B. Summary of Significant Issues Raised by Public Comments in Response to the IRFA**

5. There were no comments filed that specifically address the rules and policies proposed in the IRFA.

**C. Response to Comments by the Chief Counsel for Advocacy of the Small Business Administration**

6. Pursuant to the Small Business Jobs Act of 2010,<sup>16</sup> which amended the RFA, the Commission is required to respond to any comments filed by the Chief Counsel of the Small Business Administration (SBA), and to provide a detailed statement of any change made to the proposed rule(s) as a result of those comments.<sup>17</sup> The Chief Counsel did not file any comments in response to the proposed rule(s) in this proceeding.

**D. Description and Estimate of the Number of Small Entities to Which the Rules Will Apply**

7. The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted.<sup>18</sup> The RFA generally defines the term “small entity” as having the same meaning as the terms “small business,” “small organization,” and “small governmental jurisdiction.”<sup>19</sup> In addition, the term “small business” has the same meaning as the term “small business concern” under the Small Business Act.<sup>20</sup> A small business concern is one that: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the SBA.<sup>21</sup>

8. *Small Businesses, Small Organizations, Small Governmental Jurisdictions.* Our actions, over time, may affect small entities that are not easily categorized at present. We therefore describe here, at the outset, three broad groups of small entities that could be directly affected herein.<sup>22</sup> First, while there are industry specific size standards for small businesses that are used in the RFA, according to data from the SBA’s Office of Advocacy, in general a small business is an independent business having fewer than 500 employees.<sup>23</sup> These types of small businesses represent 99.9 percent of all businesses in the United States, which translates to 28.8 million businesses.<sup>24</sup>

9. Next, the type of small entity described as a “small organization” is generally “any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.”<sup>25</sup>

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<sup>16</sup> 5 U.S.C. § 604(a)(3).

<sup>17</sup> *Id.*

<sup>18</sup> 5 U.S.C. § 603(b)(3).

<sup>19</sup> 5 U.S.C. § 601(6).

<sup>20</sup> 5 U.S.C. § 601(3) (incorporating by reference the definition of “small business concern” in 15 U.S.C. § 632). Pursuant to the RFA, the statutory definition of a small business applies “unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register.” *Id.*

<sup>21</sup> See 15 U.S.C. § 632.

<sup>22</sup> See 5 U.S.C. § 601(3)-(6).

<sup>23</sup> See SBA, Office of Advocacy, *Frequently Asked Questions*, Question 1: What is a small business?, [https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016\\_WEB.pdf](https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016_WEB.pdf) (last visited June 6, 2018).

<sup>24</sup> See SBA, Office of Advocacy, *Frequently Asked Questions*, Question 2: How many small businesses are there in the U.S.?, [https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016\\_WEB.pdf](https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016_WEB.pdf) (last visited June 6, 2018).

<sup>25</sup> 5 U.S.C. § 601(4).



Nationwide, as of August 2016, there were approximately 356,494 small organizations based on registration and tax data filed by nonprofits with the Internal Revenue Service (IRS).<sup>26</sup>

10. Finally, the small entity described as a “small governmental jurisdiction” is defined generally as “governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than fifty thousand.”<sup>27</sup> U.S. Census Bureau data from the 2012 Census of Governments<sup>28</sup> indicate that there were 90,056 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States.<sup>29</sup> Of this number, there were 37,132 General purpose governments (county,<sup>30</sup> municipal and town or township<sup>31</sup>) with populations of less than 50,000 and 12,184 Special purpose governments (independent school districts<sup>32</sup> and special districts<sup>33</sup>) with populations of less than 50,000. The 2012 U.S. Census Bureau data for most types of governments in the local government category show that the majority of these governments have

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<sup>26</sup> Data from the Urban Institute, National Center for Charitable Statistics (NCCS) reporting on nonprofit organizations registered with the IRS was used to estimate the number of small organizations. Reports generated using the NCCS online database indicated that as of August 2016 there were 356,494 registered nonprofits with total revenues of less than \$100,000. Of this number, 326,897 entities filed tax returns with 65,113 registered nonprofits reporting total revenues of \$50,000 or less on the IRS Form 990-N for Small Exempt Organizations and 261,784 nonprofits reporting total revenues of \$100,000 or less on some other version of the IRS Form 990 within 24 months of the August 2016 data release date. See NCCS Web Tools, *NCCS Nonprofits*, <http://nccs.urban.org/sites/all/nccs-archive/html/tablewiz/tw.php> (last visited June 6, 2018) (where the report showing this data can be generated by selecting the following data fields: Report: “The Number and Finances of All Registered 501(c) Nonprofits”; Show: “Registered Nonprofit Organizations”; By: “Total Revenue Level (years 1995, Aug to 2016, Aug)”; and For: “2016, Aug” then selecting “Show Results”).

<sup>27</sup> 5 U.S.C. § 601(5).

<sup>28</sup> See 13 U.S.C. § 161. The Census of Governments is conducted every five (5) years compiling data for years ending with “2” and “7.” See U.S. Census Bureau, *Program Census of Governments*, <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=program&id=program.en.COG#> (last visited June 6, 2018).

<sup>29</sup> See U.S. Census Bureau, *2012 Census of Governments, Local Governments by Type and State: 2012 - United States-States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG02.US01> (last visited June 6, 2018) (local governmental jurisdictions are classified in two categories - general purpose governments (county, municipal and town or township) and special purpose governments (special districts and independent school districts)).

<sup>30</sup> See U.S. Census Bureau, *2012 Census of Governments, County Governments by Population-Size Group and State: 2012 - United States-States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG06.US01> (last visited June 6, 2018) (2012 Census, *County Governments by Population-Size Group and State*). There were 2,114 county governments with populations less than 50,000.

<sup>31</sup> See U.S. Census Bureau, *2012 Census of Governments, Subcounty General-Purpose Governments by Population-Size Group and State: 2012 - United States – States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG07.US01> (last visited June 6, 2018) (2012 Census, *Subcounty General-Purpose Governments by Population-Size Group and State*). There were 18,811 municipal and 16,207 town and township governments with populations less than 50,000.

<sup>32</sup> See U.S. Census Bureau, *2012 Census of Governments, Elementary and Secondary School Systems by Enrollment-Size Group and State: 2012 - United States-States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG11.US01> (last visited June 6, 2018) (2012 Census, *Elementary and Secondary School Systems by Enrollment-Size Group and State*). There were 12,184 independent school districts with enrollment populations less than 50,000.

<sup>33</sup> See U.S. Census Bureau, *2012 Census of Governments, Special District Governments by Function and State: 2012 - United States-States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG09.US01> (last visited June 6, 2018). The U.S. Census Bureau data did not provide a population breakout for special district governments.

populations of less than 50,000.<sup>34</sup> Based on this data we estimate that at least 49,316 local government jurisdictions fall in the category of “small governmental jurisdictions.”<sup>35</sup>

11. Small entities potentially affected by the reforms adopted herein include eligible non-profit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, Internet Service Providers (ISPs), and service providers of the services and equipment used for dedicated broadband networks.<sup>36</sup>

### 1. Health Care Providers

12. *Offices of Physicians (except Mental Health Specialists).* This U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or health maintenance organization (HMO) medical centers.<sup>37</sup> The SBA has created a size standard for this industry, which is annual receipts of \$11 million or less.<sup>38</sup> According to 2012 U.S. Economic Census, 152,468 firms operated throughout the entire year in this industry.<sup>39</sup> Of that number, 147,718 had annual receipts of less than \$10 million, while 3,108 firms had annual receipts between \$10 million and \$24,999,999.<sup>40</sup> Based on this data, we conclude that a majority of firms operating in this industry are small under the applicable size standard.

13. *Offices of Physicians, Mental Health Specialists.* The U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of psychiatry or psychoanalysis. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.<sup>41</sup> The SBA has established a size standard for businesses in this industry, which is annual receipts of \$11 million dollars or less.<sup>42</sup> The U.S.

<sup>34</sup> See 2012 Census, County Governments by Population-Size Group and State; 2012 Census, Subcounty General-Purpose Governments by Population-Size Group and State; 2012 Census, Elementary and Secondary School Systems by Enrollment-Size Group and State. While U.S. Census Bureau data did not provide a population breakout for special district governments, if the population of less than 50,000 for this category of local government is consistent with the other types of local governments the majority of the 38,266 special district governments have populations of less than 50,000.

<sup>35</sup> See 2012 Census, Subcounty General-Purpose Governments by Population-Size Group and State; 2012 Census, Elementary and Secondary School Systems by Enrollment-Size Group and State.

<sup>36</sup> 47 CFR §§ 54.601, 54.621.

<sup>37</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621111 “Offices of Physicians (except Mental Health Specialists),” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621111&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>38</sup> 13 CFR § 121.201, NAICS Code 621111.

<sup>39</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621111, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621111](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621111) (last visited June 6, 2018).

<sup>40</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

<sup>41</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621112 “Offices of Physicians, Mental Health Specialists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621112&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>42</sup> 13 CFR § 121.201; NAICS Code 621112.

Economic Census indicates that 8,809 firms operated throughout the entire year in this industry.<sup>43</sup> Of that number 8,791 had annual receipts of less than \$10 million, while 13 firms had annual receipts between \$10 million and \$24,999,999.<sup>44</sup> Based on this data, we conclude that a majority of firms in this industry are small under the applicable standard.

14. *Offices of Dentists.* This U.S. industry comprises establishments of health practitioners having the degree of D.M.D. (Doctor of Dental Medicine), D.D.S. (Doctor of Dental Surgery), or D.D.S. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialize in a single field of dentistry.<sup>45</sup> The SBA has established a size standard for that industry of annual receipts of \$7.5 million or less.<sup>46</sup> The 2012 U.S. Economic Census indicates that 115,268 firms operated in the dental industry throughout the entire year.<sup>47</sup> Of that number 114,417 had annual receipts of less than \$5 million, while 651 firms had annual receipts between \$5 million and \$9,999,999.<sup>48</sup> Based on this data, we conclude that a majority of business in the dental industry are small under the applicable standard.

15. *Offices of Chiropractors.* This U.S. industry comprises establishments of health practitioners having the degree of D.C. (Doctor of Chiropractic) primarily engaged in the independent practice of chiropractic. These practitioners provide diagnostic and therapeutic treatment of neuromusculoskeletal and related disorders through the manipulation and adjustment of the spinal column and extremities, and operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.<sup>49</sup> The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.<sup>50</sup> The 2012 U.S. Economic Census statistics show that in 2012, there were 33,940 firms operated throughout the entire year.<sup>51</sup> Of that

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<sup>43</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621112, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621112](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621112) (last visited June 6, 2018).

<sup>44</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

<sup>45</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621210 “Offices of Dentists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621210&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>46</sup> 13 CFR § 121.201; NAICS Code 621210.

<sup>47</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621210, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621210](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621210) (last visited June 6, 2018).

<sup>48</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

<sup>49</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621310 “Offices of Chiropractors,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621310&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018). See also NAICS Code 621310; 13 CFR § 121.201.

<sup>50</sup> 13 CFR § 121.201; NAICS Code 621310.

<sup>51</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621310, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621310](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621310) (last visited June 6, 2018).

number 33,910 operated with annual receipts of less than \$5 million per year, while 26 firms had annual receipts between \$5 million and \$9,999,999.<sup>52</sup> Based on that data, we conclude that a majority of chiropractors are small.

16. *Offices of Optometrists.* This U.S. industry comprises establishments of health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of optometry. These practitioners examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnose related systemic conditions. Offices of optometrists prescribe and/or provide eyeglasses, contact lenses, low vision aids, and vision therapy. They operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers, and may also provide the same services as opticians, such as selling and fitting prescription eyeglasses and contact lenses.<sup>53</sup> The SBA has established a size standard for businesses operating in this industry, which is annual receipts of \$7.5 million or less.<sup>54</sup> The 2012 Economic Census indicates that 18,050 firms operated the entire year.<sup>55</sup> Of that number, 17,951 had annual receipts of less than \$5 million, while 70 firms had annual receipts between \$5 million and \$9,999,999.<sup>56</sup> Based on this data, we conclude that a majority of optometrists in this industry are small.

17. *Offices of Mental Health Practitioners (except Physicians).* This U.S. industry comprises establishments of independent mental health practitioners (except physicians) primarily engaged in (1) the diagnosis and treatment of mental, emotional, and behavioral disorders and/or (2) the diagnosis and treatment of individual or group social dysfunction brought about by such causes as mental illness, alcohol and substance abuse, physical and emotional trauma, or stress. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.<sup>57</sup> The SBA has created a size standard for this industry, which is annual receipts of \$7.5 million or less.<sup>58</sup> The 2012 U.S. Economic Census indicates that 16,058 firms operated throughout the entire year.<sup>59</sup> Of that number, 15,894 firms received annual receipts of less than \$5 million, while 111 firms had annual receipts between \$5 million and \$9,999,999.<sup>60</sup> Based on this data, we

<sup>52</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

<sup>53</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621320 “Offices of Optometrists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621320&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>54</sup> 13 CFR § 121.201; NAICS Code 621320.

<sup>55</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621320, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621320](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621320) (last visited June 6, 2018).

<sup>56</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

<sup>57</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621330 “Offices of Mental Health Practitioners (except Physicians),” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621330&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>58</sup> 13 CFR § 121.201; NAICS Code 621330.

<sup>59</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621330, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621330](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621330) (last visited June 6, 2018).

<sup>60</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

conclude that a majority of mental health practitioners who do not employ physicians are small.

18. *Offices of Physical, Occupational and Speech Therapists and Audiologists.* This U.S. industry comprises establishments of independent health practitioners primarily engaged in one of the following: (1) providing physical therapy services to patients who have impairments, functional limitations, disabilities, or changes in physical functions and health status resulting from injury, disease or other causes, or who require prevention, wellness or fitness services; (2) planning and administering educational, recreational, and social activities designed to help patients or individuals with disabilities, regain physical or mental functioning or to adapt to their disabilities; and (3) diagnosing and treating speech, language, or hearing problems. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.<sup>61</sup> The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.<sup>62</sup> The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year.<sup>63</sup> Of this number, 20,047 had annual receipts of less than \$5 million, while 270 firms had annual receipts between \$5 million and \$9,999,999.<sup>64</sup> Based on this data, we conclude that a majority of businesses in this industry are small.

19. *Offices of Podiatrists.* This U.S. industry comprises establishments of health practitioners having the degree of D.P.M. (Doctor of Podiatric Medicine) primarily engaged in the independent practice of podiatry. These practitioners diagnose and treat diseases and deformities of the foot and operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.<sup>65</sup> The SBA has established a size standard for businesses in this industry, which is annual receipts of \$7.5 million or less.<sup>66</sup> The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year.<sup>67</sup> Of that number, 7,545 firms had annual receipts of less than \$5 million, while 22 firms had annual receipts between \$5 million and \$9,999,999.<sup>68</sup> Based on this data, we conclude that a majority of firms in this industry are small.

20. *Offices of All Other Miscellaneous Health Practitioners.* This U.S. industry comprises establishments of independent health practitioners (except physicians; dentists; chiropractors; optometrists; mental health specialists; physical, occupational, and speech therapists; audiologists; and

<sup>61</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621340 “Offices of Physical, Occupational and Speech Therapists and Audiologists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621340&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>62</sup> 13 CFR § 121.201; NAICS Code 621340.

<sup>63</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621340, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621340](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621340) (last visited June 6, 2018).

<sup>64</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

<sup>65</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621391 “Offices of Podiatrists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621391&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>66</sup> 13 CFR § 121.201; NAICS Code 621391.

<sup>67</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621391, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621391](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621391) (last visited June 6, 2018).

<sup>68</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.



podiatrists). These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.<sup>69</sup> The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.<sup>70</sup> The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year.<sup>71</sup> Of that number, 11,374 firms had annual receipts of less than \$5 million, while 48 firms had annual receipts between \$5 million and \$9,999,999.<sup>72</sup> Based on this data, we conclude the majority of firms in this industry are small.

21. *Family Planning Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing a range of family planning services on an outpatient basis, such as contraceptive services, genetic and prenatal counseling, voluntary sterilization, and therapeutic and medically induced termination of pregnancy.<sup>73</sup> The SBA has established a size standard for this industry, which is annual receipts of \$11 million or less.<sup>74</sup> The 2012 Economic Census indicates that 1,286 firms in this industry operated throughout the entire year.<sup>75</sup> Of that number 1,237 had annual receipts of less than \$10 million, while 36 firms had annual receipts between \$10 million and \$24,999,999.<sup>76</sup> Based on this data, we conclude that the majority of firms in this industry are small.

22. *Outpatient Mental Health and Substance Abuse Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient services related to the diagnosis and treatment of mental health disorders and alcohol and other substance abuse. These establishments generally treat patients who do not require inpatient treatment. They may provide a counseling staff and information regarding a wide range of mental health and substance abuse issues and/or refer patients to more extensive treatment programs, if necessary.<sup>77</sup> The SBA has established a size standard for this industry, which is \$15 million or less in annual receipts.<sup>78</sup> The 2012 U.S. Economic

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<sup>69</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621399 “Offices of All Other Miscellaneous Health Practitioners,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621399&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>70</sup> 13 CFR § 121.201; NAICS Code 621399.

<sup>71</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621399, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621399](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621399) (last visited June 6, 2018).

<sup>72</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

<sup>73</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621410 “Family Planning Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621410&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>74</sup> 13 CFR § 121.201; NAICS Code 621410.

<sup>75</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621410, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621410](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621410) (last visited June 6, 2018).

<sup>76</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

<sup>77</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621420 “Outpatient Mental Health and Substance Abuse Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621420&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>78</sup> 13 CFR § 121.201; NAICS Code 621420.



Census indicates that 4,446 firms operated throughout the entire year.<sup>79</sup> Of that number, 4,069 had annual receipts of less than \$10 million while 286 firms had annual receipts between \$10 million and \$24,999,999.<sup>80</sup> Based on this data, we conclude that a majority of firms in this industry are small.

23. *HMO Medical Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in providing a range of outpatient medical services to the HMO subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included in this industry are HMO establishments that both provide health care services and underwrite health and medical insurance policies.<sup>81</sup> The SBA has established a size standard for this industry, which is \$32.5 million or less in annual receipts.<sup>82</sup> The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year.<sup>83</sup> Of that number, 5 firms had annual receipts of less than \$25 million, while 1 firm had annual receipts between \$25 million and \$99,999,999.<sup>84</sup> Based on this data, we conclude that approximately one-third of the firms in this industry are small.

24. *Freestanding Ambulatory Surgical and Emergency Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in (1) providing surgical services (e.g., orthoscopic and cataract surgery) on an outpatient basis or (2) providing emergency care services (e.g., setting broken bones, treating lacerations, or tending to patients suffering injuries as a result of accidents, trauma, or medical conditions necessitating immediate medical care) on an outpatient basis. Outpatient surgical establishments have specialized facilities, such as operating and recovery rooms, and specialized equipment, such as anesthetic or X-ray equipment.<sup>85</sup> The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.<sup>86</sup> The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year.<sup>87</sup> Of that number, 3,222 firms had annual receipts of less than \$10 million, while 289 firms had annual

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<sup>79</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621420, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621420](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621420) (last visited June 6, 2018).

<sup>80</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

<sup>81</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621491 “HMO Medical Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621491&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>82</sup> 13 CFR § 121.201; NAICS Code 621491.

<sup>83</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621491, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621491](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621491) (last visited June 6, 2018).

<sup>84</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

<sup>85</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621493 “Freestanding Ambulatory Surgical and Emergency Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621493&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>86</sup> 13 CFR § 121.201; NAICS Code 621493.

<sup>87</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621493, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621493](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621493) (last visited June 6, 2018).

receipts between \$10 million and \$24,999,999.<sup>88</sup> Based on this data, we conclude that a majority of firms in this industry are small.

25. *All Other Outpatient Care Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing general or specialized outpatient care (except family planning centers, outpatient mental health and substance abuse centers, HMO medical centers, kidney dialysis centers, and freestanding ambulatory surgical and emergency centers). Centers or clinics of health practitioners with different degrees from more than one industry practicing within the same establishment (i.e., Doctor of Medicine and Doctor of Dental Medicine) are included in this industry.<sup>89</sup> The SBA has established a size standard for this industry, which is annual receipts of \$20.5 million or less.<sup>90</sup> The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout the entire year.<sup>91</sup> Of this number, 4,269 firms had annual receipts of less than \$10 million, while 389 firms had annual receipts between \$10 million and \$24,999,999.<sup>92</sup> Based on this data, we conclude that a majority of firms in this industry are small.

26. *Blood and Organ Banks.* This U.S. industry comprises establishments primarily engaged in collecting, storing, and distributing blood and blood products and storing and distributing body organs.<sup>93</sup> The SBA has established a size standard for this industry, which is annual receipts of \$32.5 million or less.<sup>94</sup> The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year.<sup>95</sup> Of that number, 235 operated with annual receipts of less than \$25 million, while 41 firms had annual receipts between \$25 million and \$49,999,999.<sup>96</sup> Based on this data, we conclude that approximately three-quarters of firms that operate in this industry are small.

27. *All Other Miscellaneous Ambulatory Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing ambulatory health care services (except offices of physicians, dentists, and other health practitioners; outpatient care centers; medical and diagnostic

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<sup>88</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

<sup>89</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621498 “All Other Outpatient Care Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621498&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>90</sup> 13 CFR § 121.201; NAICS Code 621498.

<sup>91</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621498, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621498](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621498) (last visited June 6, 2018).

<sup>92</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$20.5 million or less.

<sup>93</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621991 “Blood and Organ Banks,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621991&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>94</sup> 13 CFR § 121.201; NAICS Code 621991.

<sup>95</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621991, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621991](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621991) (last visited June 6, 2018).

<sup>96</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

laboratories; home health care providers; ambulances; and blood and organ banks).<sup>97</sup> The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.<sup>98</sup> The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year.<sup>99</sup> Of that number, 2,318 had annual receipts of less than \$10 million, while 56 firms had annual receipts between \$10 million and \$24,999,999.<sup>100</sup> Based on this data, we conclude that a majority of the firms in this industry are small.

28. *Medical Laboratories.* This U.S. industry comprises establishments known as medical laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis, generally to the medical profession or to the patient on referral from a health practitioner.<sup>101</sup> The SBA has established a size standard for this industry, which is annual receipts of \$32.5 million or less.<sup>102</sup> The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year.<sup>103</sup> Of this number, 2,465 had annual receipts of less than \$25 million, while 60 firms had annual receipts between \$25 million and \$49,999,999.<sup>104</sup> Based on this data, we conclude that a majority of firms that operate in this industry are small.

29. *Diagnostic Imaging Centers.* This U.S. industry comprises establishments known as diagnostic imaging centers primarily engaged in producing images of the patient generally on referral from a health practitioner.<sup>105</sup> The SBA has established size standard for this industry, which is annual receipts of \$15 million or less.<sup>106</sup> The 2012 U.S. Economic Census indicates that 4,209 firms operated in this industry throughout the entire year.<sup>107</sup> Of that number, 3,876 firms had annual receipts of less than

<sup>97</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621999 “All Other Miscellaneous Ambulatory Health Care Services,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621999&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>98</sup> 13 CFR § 121.201; NAICS Code 621999.

<sup>99</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621999, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621999](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621999) (last visited June 6, 2018).

<sup>100</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

<sup>101</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621511 “Medical Laboratories,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621511&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>102</sup> 13 CFR § 121.201; NAICS Code 621511.

<sup>103</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621511, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621511](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621511) (last visited June 6, 2018).

<sup>104</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

<sup>105</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621512 “Diagnostic Imaging Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621512&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>106</sup> 13 CFR § 121.201; NAICS Code 621512.

<sup>107</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621512, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621512](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621512) (last visited June 6, 2018).

\$10 million, while 228 firms had annual receipts between \$10 million and \$24,999,999.<sup>108</sup> Based on this data, we conclude that a majority of firms that operate in this industry are small.

30. *Home Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24-hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy.<sup>109</sup> The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.<sup>110</sup> The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year.<sup>111</sup> Of that number, 16,822 had annual receipts of less than \$10 million, while 590 firms had annual receipts between \$10 million and \$24,999,999.<sup>112</sup> Based on this data, we conclude that a majority of firms that operate in this industry are small.

31. *Ambulance Services.* This U.S. industry comprises establishments primarily engaged in providing transportation of patients by ground or air, along with medical care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel.<sup>113</sup> The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.<sup>114</sup> The 2012 U.S. Economic Census indicates that 2,984 firms operated in this industry throughout the entire year.<sup>115</sup> Of that number, 2,926 had annual receipts of less than \$15 million, while 133 firms had annual receipts between \$10 million and \$24,999,999.<sup>116</sup> Based on this data, we conclude that a majority of firms in this industry are small.

32. *Kidney Dialysis Centers.* This U.S. industry comprises establishments with medical staff

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<sup>108</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

<sup>109</sup> See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621610 “Home Health Care Services,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621610&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>110</sup> 13 CFR § 121.201; NAICS Code 621610.

<sup>111</sup> U.S. Census Bureau, 2012 Economic Census of the United States, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621610, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621610](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621610) (last visited June 6, 2018).

<sup>112</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

<sup>113</sup> See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621910 “Ambulance Services,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621910&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>114</sup> 13 CFR § 121.201; NAICS Code 621910.

<sup>115</sup> U.S. Census Bureau, 2012 Economic Census of the United States, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621910, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621910](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621910) (last visited June 6, 2018).

<sup>116</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

primarily engaged in providing outpatient kidney or renal dialysis services.<sup>117</sup> The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.<sup>118</sup> The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year.<sup>119</sup> Of that number, 379 had annual receipts of less than \$25 million, while 7 firms had annual receipts between \$25 million and \$49,999,999.<sup>120</sup> Based on this data, we conclude that a majority of firms in this industry are small.

33. *General Medical and Surgical Hospitals.* This U.S. industry comprises establishments known and licensed as general medical and surgical hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with any of a wide variety of medical conditions. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. These hospitals have an organized staff of physicians and other medical staff to provide patient care services. These establishments usually provide other services, such as outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services.<sup>121</sup> The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.<sup>122</sup> The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year.<sup>123</sup> Of that number, 877 has annual receipts of less than \$25 million, while 400 firms had annual receipts between \$25 million and \$49,999,999.<sup>124</sup> Based on this data, we conclude that approximately one-quarter of firms in this industry are small.

34. *Psychiatric and Substance Abuse Hospitals.* This U.S. industry comprises establishments known and licensed as psychiatric and substance abuse hospitals primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. Psychiatric, psychological, and social work services are available at the facility. These hospitals usually provide other services, such as outpatient services, clinical laboratory services,

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<sup>117</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621492 “Kidney Dialysis Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621492&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>118</sup> 13 CFR § 121.201; NAICS Code 621492.

<sup>119</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621492, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-621492](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621492) (last visited June 6, 2018).

<sup>120</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

<sup>121</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622110 “General Medical and Surgical Hospitals,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622110&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>122</sup> 13 CFR § 121.201; NAICS Code 622110.

<sup>123</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 622110, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-622110](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-622110) (last visited June 6, 2018).

<sup>124</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.



diagnostic X-ray services, and electroencephalograph services.<sup>125</sup> The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.<sup>126</sup> The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year.<sup>127</sup> Of that number, 185 had annual receipts of less than \$25 million, while 107 firms had annual receipts between \$25 million and \$49,999,999.<sup>128</sup> Based on this data, we conclude that more than one-half of the firms in this industry are small.

35. *Specialty (Except Psychiatric and Substance Abuse) Hospitals.* This U.S. industry consists of establishments known and licensed as specialty hospitals primarily engaged in providing diagnostic, and medical treatment to inpatients with a specific type of disease or medical condition (except psychiatric or substance abuse). Hospitals providing long-term care for the chronically ill and hospitals providing rehabilitation, restorative, and adjustive services to physically challenged or disabled people are included in this industry. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. These hospitals may provide other services, such as outpatient services, diagnostic X-ray services, clinical laboratory services, operating room services, physical therapy services, educational and vocational services, and psychological and social work services.<sup>129</sup> The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.<sup>130</sup> The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year.<sup>131</sup> Of that number, 146 firms had annual receipts of less than \$25 million, while 79 firms had annual receipts between \$25 million and \$49,999,999.<sup>132</sup> Based on this data, we conclude that more than one-half of the firms in this industry are small.

36. *Emergency and Other Relief Services.* This industry comprises establishments primarily engaged in providing food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts (e.g., wars).<sup>133</sup> The SBA has established a size standard for

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<sup>125</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622210 “Psychiatric and Substance Abuse Hospitals,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622210&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>126</sup> 13 CFR § 121.201; NAICS Code 622210.

<sup>127</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 622210, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-622210](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-622210) (last visited June 6, 2018).

<sup>128</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

<sup>129</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622310 “Specialty (Except Psychiatric and Substance Abuse) Hospitals,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622310&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

<sup>130</sup> 13 CFR § 121.201; NAICS Code 622310.

<sup>131</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 622310, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-622310](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-622310) (last visited June 6, 2018).

<sup>132</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

<sup>133</sup> See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 624230 “Emergency and Other Relief Services,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=624230&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).



this industry, which is annual receipts of \$32.5 million or less.<sup>134</sup> The 2012 U.S. Economic Census indicates that 541 firms operated in this industry throughout the entire year.<sup>135</sup> Of that number, 509 had annual receipts of less than \$25 million, while 7 firms had annual receipts between \$25 million and \$49,999,999.<sup>136</sup> Based on this data, we conclude that a majority of firms in this industry are small

## 2. Providers of Telecommunications and Other Services

### a. Telecommunications Service Providers

37. *Incumbent Local Exchange Carriers (LECs)*. Neither the Commission nor the SBA has developed a small business size standard specifically for incumbent local exchange services. The closest applicable NAICS Code category is Wired Telecommunications Carriers and under the SBA size standard, such a business is small if it has 1,500 or fewer employees.<sup>137</sup> U.S. Census Bureau data for 2012 indicate that 3,117 firms operated during that year. Of this total, 3,083 operated with fewer than 1,000 employees.<sup>138</sup> Consequently, the Commission estimates that most providers of incumbent local exchange service are small businesses that may be affected by our actions. According to Commission data, one thousand three hundred and seven (1,307) Incumbent Local Exchange Carriers reported that they were incumbent local exchange service providers.<sup>139</sup> Of this total, an estimated 1,006 have 1,500 or fewer employees.<sup>140</sup> Thus, using the SBA's size standard the majority of Incumbent LECs can be considered small entities.

38. *Interexchange Carriers (IXCs)*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to providers of IXCs. The closest NAICS Code category is Wired Telecommunications Carriers and the applicable size standard under SBA rules consists of all such companies having 1,500 or fewer employees.<sup>141</sup> U.S. Census Bureau data for 2012 indicate

<sup>134</sup> 13 CFR § 121.201; NAICS Code 624230.

<sup>135</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 624230, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/62SSSZ4/naics-624230](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-624230) (last visited June 6, 2018).

<sup>136</sup> *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

<sup>137</sup> See 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017, the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

<sup>138</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012*, NAICS Code 517110, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ5/naics-517110](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics-517110) (last visited June 6, 2018).

<sup>139</sup> See Federal Communications Commission, *Trends in Telephone Service* at Table 5.3 (*Trends in Telephone Service*), <https://www.fcc.gov/general/trends-telephone-service> (last visited June 6, 2018).

<sup>140</sup> *Id.*

<sup>141</sup> See 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017, the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

that 3,117 firms operated during that year.<sup>142</sup> Of that number, 3,083 operated with fewer than 1,000 employees.<sup>143</sup> According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services.<sup>144</sup> Of this total, an estimated 317 have 1,500 or fewer employees.<sup>145</sup> Consequently, the Commission estimates that the majority of interexchange service providers that may be affected are small entities.

39. *Competitive Access Providers.* Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is Wired Telecommunications Carriers and under the size standard, such a business is small if it has 1,500 or fewer employees.<sup>146</sup> U.S. Census Bureau data for 2012 indicate that 3,117 firms operated during that year.<sup>147</sup> Of that number, 3,083 operated with fewer than 1,000 employees.<sup>148</sup> Consequently, the Commission estimates that most competitive access providers are small businesses that may be affected by our actions. According to Commission data the *2010 Trends in Telephone Report*, 1,442 CAPs and competitive local exchange carriers (competitive LECs) reported that they were engaged in the provision of competitive local exchange services.<sup>149</sup> Of these 1,442 CAPs and competitive LECs, an estimated 1,256 have 1,500 or few employees and 186 have more than 1,500 employees.<sup>150</sup> Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

40. *Wired Telecommunications Carriers.* The U.S. Census Bureau defines this industry as “establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired communications networks. Transmission facilities may be based on a single technology or a combination of technologies. Establishments in this industry use the wired telecommunications network facilities that they operate to provide a variety of services, such as wired telephony services, including VoIP services, wired (cable) audio and video programming distribution, and wired broadband Internet services. By exception, establishments providing satellite television distribution services using facilities and infrastructure that they operate are included in this industry.”<sup>151</sup> The SBA has developed a small

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<sup>142</sup> See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012*, NAICS Code 517110, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ5/naics~517110](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517110) (last visited June 6, 2018).

<sup>143</sup> *Id.*

<sup>144</sup> See *Trends in Telephone Service*, at Table 5.3.

<sup>145</sup> *Id.*

<sup>146</sup> See 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017, the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

<sup>147</sup> See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012*, NAICS Code 517110, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ5/naics~517110](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517110) (last visited June 6, 2018).

<sup>148</sup> *Id.*

<sup>149</sup> See *Trends in Telephone Service*, at Table 5.3, page 5.5.

<sup>150</sup> *Id.*

<sup>151</sup> See 13 CFR § 120.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017, the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired

(continued....)

business size standard for Wired Telecommunications Carriers, which consists of all such companies having 1,500 or fewer employees.<sup>152</sup> U.S. Census data for 2012 show that there were 3,117 firms that operated that year.<sup>153</sup> Of this total, 3,083 operated with fewer than 1,000 employees.<sup>154</sup> Thus, under this size standard, the majority of firms in this industry can be considered small.

41. *Wireless Telecommunications Carriers (except Satellite)*. This industry comprises establishments engaged in operating and maintaining switching and transmission facilities to provide communications via the airwaves. Establishments in this industry have spectrum licenses and provide services using that spectrum, such as cellular services, paging services, wireless internet access, and wireless video services.<sup>155</sup> The appropriate size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.<sup>156</sup> For this industry, U.S. Census Bureau data for 2012 shows that there were 967 firms that operated for the entire year.<sup>157</sup> Of this total, 955 firms had employment of 999 or fewer employees and 12 had employment of 1000 employees or more.<sup>158</sup> Thus, under this category and the associated size standard, the Commission estimates that the majority of wireless telecommunications carriers (except satellite) are small entities.

42. The Commission's own data—available in its Universal Licensing System—indicate that, as of October 25, 2016, there are 280 Cellular licensees that will be affected by our actions today.<sup>159</sup> The Commission does not know how many of these licensees are small, as the Commission does not collect that information for these types of entities. Similarly, according to internally developed Commission data, 413 carriers reported that they were engaged in the provision of wireless telephony, including cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services.<sup>160</sup> Of this total, an estimated 261 have 1,500 or fewer employees, and 152 have more than 1,500 employees.<sup>161</sup> Thus, using available data, we estimate that the majority of wireless firms can

(Continued from previous page)

Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

<sup>152</sup> See U.S. Census Bureau, *2017 NAICS Definition*, NAICS Code 517311 “Wired Telecommunications Carriers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

<sup>153</sup> See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012*, NAICS Code 517110, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ5/naics~517110](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517110) (last visited June 6, 2018).

<sup>154</sup> *Id.*

<sup>155</sup> NAICS Code 517210. See U.S. Census Bureau, *Program, Survey, Data Set, Dimension, Industry Code, Wireless telecommunications carriers (except satellite)*, <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en/ECN.NAICS2012.517210> (last visited June 6, 2018).

<sup>156</sup> 13 CFR § 121.201; NAICS Code 517210.

<sup>157</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012*, NAICS Code 517210, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ5/naics~517210](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517210) (last visited June 6, 2018).

<sup>158</sup> *Id.* Available census data does not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with “1000 employees or more.”

<sup>159</sup> See Federal Communications Commission, *Universal Licensing System*, <http://wireless.fcc.gov/uls/index.htm?job=home> (last visited June 6, 2018). For the purposes of this FRFA, consistent with Commission practice for wireless services, the Commission estimates the number of licensees based on the number of unique FCC Registration Numbers.

<sup>160</sup> See *Trends in Telephone Service* at Table 5.3.

<sup>161</sup> See *id.*

be considered small.

43. *Wireless Telephony.* Wireless telephony includes cellular, personal communications services, and specialized mobile radio telephony carriers. The closest applicable SBA category is Wireless Telecommunications Carriers (except Satellite)<sup>162</sup> and the appropriate size standard for this category under the SBA rules is that such a business is small if it has 1,500 or fewer employees.<sup>163</sup> For this industry, U.S. Census Bureau data for 2012 show that there were 967 firms that operated for the entire year.<sup>164</sup> Of this total, 955 firms had fewer than 1,000 employees and 12 firms has 1000 employees or more.<sup>165</sup> Thus, under this category and the associated size standard, the Commission estimates that a majority of these entities can be considered small. According to Commission data, 413 carriers reported that they were engaged in wireless telephony.<sup>166</sup> Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees.<sup>167</sup> Therefore, more than half of these entities can be considered small.

44. *Satellite Telecommunications.* This category comprises firms “primarily engaged in providing telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or reselling satellite telecommunications.”<sup>168</sup> Satellite telecommunications service providers include satellite and earth station operators. The category has a small business size standard of \$32.5 million or less in average annual receipts, under SBA rules.<sup>169</sup> For this category, U.S. Census Bureau data for 2012 shows that there were a total of 333 firms that operated for the entire year.<sup>170</sup> Of this total, 299 firms had annual receipts of less than \$25 million.<sup>171</sup> Consequently, we estimate that the majority of satellite telecommunications providers are small entities.

45. *All Other Telecommunications.* The “All Other Telecommunications” category is comprised of establishments that are primarily engaged in providing specialized telecommunications services, such as satellite tracking, communications telemetry, and radar station operation.<sup>172</sup> This industry also includes establishments primarily engaged in providing satellite terminal stations and associated facilities connected with one or more terrestrial systems and capable of transmitting

<sup>162</sup> 13 CFR § 121.201; NAICS Code 517210.

<sup>163</sup> 13 CFR § 121.201; NAICS Code 517210.

<sup>164</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012*, NAICS Code 517210, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ5/naics~517210](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517210) (last visited June 6, 2018).

<sup>165</sup> *Id.* Available census data do not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with “1000 employees or more.”

<sup>166</sup> *See Trends in Telephone Service* at Table 5.3.

<sup>167</sup> *Id.*

<sup>168</sup> U.S. Census Bureau, *2017 NAICS Definitions*, NAICS Code “517410 Satellite Telecommunications”; <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=517410&search=2017+NAICS+Search&search=2017> (last visited June 6, 2018).

<sup>169</sup> 13 CFR § 121.201; NAICS Code 517410.

<sup>170</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the United States: 2012*, NAICS Code 517410, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ4/naics~517410](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ4/naics~517410) (last visited June 6, 2018).

<sup>171</sup> *Id.*

<sup>172</sup> *See* U.S. Census Bureau, *2017 NAICS Definitions*, NAICS Code “517919 All Other Telecommunications,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=517919&search=2017+NAICS+Search&search=2017> (last visited June 6, 2018).

telecommunications to, and receiving telecommunications from, satellite systems.<sup>173</sup> Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry.<sup>174</sup> The SBA has developed a small business size standard for “All Other Telecommunications,” which consists of all such firms with gross annual receipts of \$32.5 million or less.<sup>175</sup> For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year.<sup>176</sup> Of these firms, a total of 1,400 had gross annual receipts of less than \$25 million and 42 firms had gross annual receipts of \$25 million to \$49,999,999.<sup>177</sup> Thus, the Commission estimates that a majority of “All Other Telecommunications” firms potentially affected by our action can be considered small.

**b. Internet Service Providers**

46. *Internet Service Providers (Broadband)*. Broadband Internet service providers include wired (e.g., cable, DSL) and VoIP service providers using their own operated wired telecommunications infrastructure fall in the category of Wired Telecommunication Carriers.<sup>178</sup> Wired Telecommunications Carriers are comprised of establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired telecommunications networks. Transmission facilities may be based on a single technology or a combination of technologies.<sup>179</sup> The SBA size standard for this category classifies a business as small if it has 1,500 or fewer employees.<sup>180</sup> U.S. Census Bureau data for 2012 show that there were 3,117 firms that operated that year. Of this total, 3,083 operated with fewer than 1,000 employees.<sup>181</sup> Consequently, under this size standard, the majority of firms in this industry can be considered small.

47. *Internet Service Providers (Non-Broadband)*. Internet access service providers such as Dial-up Internet service providers, VoIP service providers using client-supplied telecommunications connections and Internet service providers using client-supplied telecommunications connections (e.g., dial-up ISPs) fall in the category of All Other Telecommunications. The SBA has developed a small business size standard for All Other Telecommunications, which consists of all such firms with gross annual receipts of \$32.5 million or less.<sup>182</sup> For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year. Of these firms, a total of 1,400 had gross annual

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<sup>173</sup> *Id.*

<sup>174</sup> *Id.*

<sup>175</sup> 13 CFR § 121.201; NAICS Code 517919.

<sup>176</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the United States: 2012*, NAICS Code 517919, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ4/naics~517919](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ4/naics~517919) (last visited June 6, 2018).

<sup>177</sup> *Id.*

<sup>178</sup> See 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017 the U.S. Census Bureau definition show the NAICS Code as 517311. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018) (*2017 NAICS Definition, 517311 Wired Telecommunications Carriers*).

<sup>179</sup> *2017 NAICS Definition, 517311 Wired Telecommunications Carriers*.

<sup>180</sup> *Id.*

<sup>181</sup> See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012*, NAICS Code 517110, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/51SSSZ5/naics~517110](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517110) (last visited June 6, 2018).

<sup>182</sup> 13 CFR § 121.201; NAICS Code 517919.



receipts of less than \$25 million.<sup>183</sup> Consequently, under this size standard, a majority of firms in this industry can be considered small.

**c. Vendors and Equipment Manufacturers**

48. *Vendors of Infrastructure Development or “Network Buildout.”* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. There are two applicable SBA categories in which manufacturers of network facilities could fall and each have different size standards under the SBA rules. The SBA categories are “Radio and Television Broadcasting and Wireless Communications Equipment” with a size standard of 1,250 employees or less<sup>184</sup> and “Other Communications Equipment Manufacturing” with a size standard of 750 employees or less.<sup>185</sup> U.S. Census Bureau data for 2012 show that for Radio and Television Broadcasting and Wireless Communications Equipment firms 841 establishments operated for the entire year.<sup>186</sup> Of that number, 828 establishments operated with fewer than 1,000 employees, 7 establishments operated with between 1,000 and 2,499 employees and 6 establishments operated with 2,500 or more employees.<sup>187</sup> For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012 show that 383 establishments operated for the year.<sup>188</sup> Of that number, 379 firms operated with fewer than 500 employees and 4 had 500 to 999 employees. Based on this data, we conclude that the majority of Vendors of Infrastructure Development or “Network Buildout” are small.

49. *Telephone Apparatus Manufacturing.* This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment. These products may be standalone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless telephones (except cellular), PBX equipment, telephones, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways.<sup>189</sup> The SBA size standard for Telephone Apparatus Manufacturing is all such firms having 1,250 or fewer employees.<sup>190</sup> According to U.S. Census Bureau data for 2012, there were a total of 266 establishments in this category that operated for the entire year.<sup>191</sup> Of this total, 262 had employment of under 1,000, and an additional 4 had

<sup>183</sup> U.S. Census Bureau, *2012 Economic Census Table*, Table EC1251SSSZ4, *Information: Subject Series - Estab & Firm Size: Receipts Size of Firms for the U.S.: 2012*, NAIC Code 517919, <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited June 6, 2018).

<sup>184</sup> 13 CFR § 121.201; NAICS Code 334220.

<sup>185</sup> 13 CFR § 121.201; NAICS Code 334290.

<sup>186</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334220, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/31SG2/naics~334220](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2/naics~334220) (last visited June 6, 2018).

<sup>187</sup> *Id.*

<sup>188</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334290, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/31SG2/naics~334290](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2/naics~334290) (last visited June 6, 2018).

<sup>189</sup> U.S. Census Bureau, *2012 NAICS Definition and Comparability*, “2012 NAICS: 334210 - Telephone apparatus manufacturing,” <https://www.census.gov/econ/isp/sampler.php?naicscode=334210&naicslevel=6#> (last visited June 6, 2018).

<sup>190</sup> 13 CFR § 121.201; NAICS Code 334210.

<sup>191</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334210, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/31SG2/naics~334210](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2/naics~334210) (last visited

(continued....)

employment of 1,000 to 2,499.<sup>192</sup> Thus, under this size standard, the majority of firms can be considered small.

50. *Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing.* This industry comprises establishments primarily engaged in manufacturing radio and television broadcast and wireless communications equipment.<sup>193</sup> Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment, pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment.<sup>194</sup> The SBA has established a small business size standard for this industry of 1,250 employees or less.<sup>195</sup> U.S. Census Bureau data for 2012 show that 841 establishments operated in this industry in that year.<sup>196</sup> Of that number, 828 establishments operated with fewer than 1,000 employees, 7 establishments operated with between 1,000 and 2,499 employees and 6 establishments operated with 2,500 or more employees.<sup>197</sup> Based on this data, we conclude that a majority of manufacturers in this industry are small.

51. *Other Communications Equipment Manufacturing.* This industry comprises establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment).<sup>198</sup> Examples of such manufacturing include fire detection and alarm systems manufacturing, Intercom systems and

(Continued from previous page) —————  
[June 6, 2018](#)). The number of “establishments” is a less helpful indicator of small business prevalence in this context than would be the number of “firms” or “companies,” because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census data for firms or companies only gives the total number of such entities for 2012, which was 250. See also U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG1, *Manufacturing: Summary Series: General Summary: Detailed Statistics by Subsectors and Industries*: 2012, NAICS Code 334210 [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/31SG1//naics~334210](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG1//naics~334210) (last visited June 6, 2018).

<sup>192</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: 2012, NAICS Code 334210, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/31SG2//naics~334210](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334210) (last visited June 6, 2018). An additional 4 establishments had employment of 2,500 or more.

<sup>193</sup> The NAICS Code for this service is 334220. 13 CFR § 121.201. See also U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 334220 “Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing,” <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en./ECN.NAICS2012.334220#> (last visited June 6, 2018).

<sup>194</sup> See also U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 334220 “Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing,” <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en./ECN.NAICS2012.334220#> (last visited June 6, 2018).

<sup>195</sup> 13 CFR § 121.201; NAICS Code 334220.

<sup>196</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: 2012, NAICS Code 334220, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/31SG2//naics~334220](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334220) (last visited June 6, 2018).

<sup>197</sup> *Id.*

<sup>198</sup> U.S. Census Bureau, *2017 NAICS Definition*, NAICS Code “334290 Other Communications Equipment Manufacturing,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=334290&search=2017+NAICS+Search&search=2017> (last visited June 6, 2018).

equipment manufacturing, and signals (e.g., highway, pedestrian, railway, traffic) manufacturing.<sup>199</sup> The SBA has established a size for this industry as all such firms having 750 or fewer employees.<sup>200</sup> U.S. Census Bureau data for 2012 show that 383 establishments operated in that year.<sup>201</sup> Of that number, 379 operated with fewer than 500 employees and 4 had 500 to 999 employees.<sup>202</sup> Based on this data, we conclude that the majority of Other Communications Equipment Manufacturers are small.

**E. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities**

52. Several of our rule changes will result in additional recordkeeping and compliance requirements for small entities. For all of those rule changes, we have determined that the benefits of an RHC Program that is more aligned with its intended mission, administratively streamlined, and stronger in its deterrence of waste, fraud, and abuse outweigh the burden of the increased recordkeeping and compliance requirements. Other rule changes decrease recordkeeping requirements for small entities and make the RHC Program administratively less burdensome.

**1. Increase in Projected Reporting, Recordkeeping and Other Compliance Requirements**

53. *Compliance burdens.* All of the rules we implement impose some burden on small entities by requiring them to become familiar with the new rules to comply with them. For many new rules such as – those determining the urban and rural rates, prioritizing funding based on rurality tiers and Medically Underserved Area/Population (MUA/P) designations, expanding the timeframe to conduct a competitive bidding process, establishing an application filing window, implementing a “fair and open” competitive bidding standard, establishing competitive bidding exemptions and gift rules – the burden of becoming familiar with the new rules, including the new format, in order to comply with them is the only burden the new rules impose.

54. *Expanding USAC’s Authorization to Extend Service Delivery Deadline.* We adopt a service delivery deadline of June 30 and four criteria for extending this deadline for non-recurring services for qualified applicants. While the Administrator will automatically extend the service delivery deadline in situations where criteria (1) and (2) are met, applicants must affirmatively request an extension and provide documentation to the Administrator for criteria (3) and (4). For those applicants seeking an extension under criteria (3) or (4), this will minimally increase their recordkeeping requirements. The benefit to rural health care providers in receiving additional time to implement eligible services outweighs this burden.

55. *Extending the Invoice Deadline.* We adopt a uniform invoice filing deadline for the RHC Program. Service providers and billed entities may request and automatically receive an extension of this deadline. For those service providers and billed entities seeking an extension, this will minimally increase their recordkeeping requirements. The benefit to rural health care providers in receiving additional time to submit their invoices to receive universal service support outweighs this burden.

56. *Strengthening Service Provider Invoice Certifications.* Requiring service providers to make additional certifications on the Telecom and Healthcare Connect Fund Program invoice forms increases their compliance requirements. However, the inclusion of these additional certifications does

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<sup>199</sup> *Id.*

<sup>200</sup> 13 CFR § 121.201, NAICS Code 334290.

<sup>201</sup> U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334290, [https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012\\_US/31SG2//naics~334290](https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334290) (last visited June 6, 2018).

<sup>202</sup> *Id.*

not impose any further burdens on service providers because, as participants in the RHC Program, they are already required to abide by RHC Program rules. These additional certifications simply serve as reminder to service providers of their current responsibilities under the RHC Program and help to further ensure compliance with the Commission's rules and program requirements as part of our ongoing efforts to reduce, waste, fraud, and abuse in the RHC Program.

57. *Site and Service Substitutions.* We align the RHC Programs and make the site and service substitution criteria under the Healthcare Connect Fund Program applicable to the Telecom Program. Those rural health care providers under the Telecom Program seeking to make such substitutions must submit requests to the Administrator with supporting documentation. While this rule will increase rural health care providers' recordkeeping requirements, the benefit to health care providers of having a mechanism to request substitutions or modifications to a site or service without modifying their funding commitment letter outweighs this burden.

58. *Service Provider Identification Number (SPIN) Changes.* We adopt a rule permitting rural health care providers to make service provider changes under certain conditions. Although this rule will increase rural health care providers' recordkeeping requirements, the benefit to rural health care providers of having a mechanism for requesting such changes and clarity on what we consider to be permissible SPIN changes under the RHC Program outweighs this burden.

59. *Requiring Applicants to Seek Bids for Particular Services.* Requiring RHC Program applicants to list the requested services for which they seek bids (e.g., Internet access, bandwidth), and to provide sufficient information to enable bidders to reasonably determine the needs of the applicant and provide responsive bids, will increase applicants' recordkeeping requirements. Nonetheless, our interest in ensuring a more equitable distribution of limited RHC Program funding justifies this burden.

60. *Cost-Effective Documentation.* Requiring applicants to submit documentation to support their certifications that they have selected the most cost-effective option increases recordkeeping requirements, but is necessary to help protect against wasteful spending and ensure that RHC Program funds can be distributed as widely and equitably as possible.

61. *Competitive Bidding Certifications and Documentation.* We take a variety of measures to harmonize our competitive bidding rules between the Telecom and Healthcare Connect Fund Programs, including harmonizing the certifications that applicants must make when requesting service, harmonizing and expanding two key competitive bidding documentation requirements, and codifying the requirement that both Telecom Program applicants and Healthcare Connect Fund Program applicants submit a declaration of assistance identifying each consultant or outside expert who aided in the preparation of their application in addition to describing the nature of the relationship. While these rules increase compliance and recordkeeping requirements, the increased burden is outweighed by the increase in competitive bidding transparency and accountability within the RHC Program.

62. *Certifications Governing Consultants.* We adopt rules requiring both rural health care providers and service providers to certify that they have not solicited or accepted a gift or any other thing of value from those seeking to participate or participating in the RHC Program. While these rules increase compliance requirements, this burden is outweighed by our interest in ensuring that the competitive bidding process is not unduly or improperly influenced by the receipt of gifts.

## **2. Decrease in Projected Reporting, Recordkeeping and Other Compliance Requirements**

63. *Cost-Based Rates.* We eliminate the cost-based mechanism for service providers to establish a rural rate, which will decrease recordkeeping requirements for those service providers that use this mechanism.

64. *Limitation of Support for Satellite Services.* We eliminate section 54.609(d) of the rules which allows rural health care providers to receive discounts for satellite service even where wireline

services are available, but caps the discount at the amount providers would have received if they purchased functionally similar wireline alternatives.<sup>203</sup> Elimination of this rule will decrease recordkeeping requirements for rural health care providers.

65. *Eliminating Distance-Based Support.* We eliminate distance-based support which allows rural health care providers to obtain support for charges based on distance. Elimination of this rule will decrease recordkeeping requirements for rural health care providers.

66. *Streamlining and Improving the RHC Program Forms and Data Collection.* Streamlining the data collection requirements and consolidating the Telecom and Healthcare Connect Fund Programs' online forms should reduce recordkeeping requirements for RHC Program participants.

67. *Data Quality and Transparency.* Requiring the Administrator to release RHC Program data in as open a manner as possible will benefit rural health care providers and service providers by enabling them to view funding and pricing information and track the status of their applications, thereby promoting competition within the RHC Program and increasing access to pertinent information.

68. *FCC Form Directions.* Providing direction on the use of the FCC Forms, should make it easier for small entities, particularly those who are new to the RHC Program or only occasionally participate in the program, to complete the forms by reducing applicant confusion and ensuring that entities have the information necessary to comply with our rules and the Administrator's procedures, and expedite the application process.

69. *Competitive Bidding Exemptions.* We adopt a rule aligning the RHC Program rules exempting certain applicants from the competitive bidding requirements in the Telecom and Healthcare Connect Fund Programs. This rule will decrease rural health care providers' recordkeeping requirements under the Telecom Program because those applicants qualifying for a competitive bidding exemption will not be required to initiate a bidding process by preparing and posting a request for services.

**F. Steps Taken to Minimize the Significant Economic Impact on Small Entities, and Significant Alternatives Considered**

70. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach, which may include (among others) the following four alternatives: (1) the establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or any part thereof, for small entities.<sup>204</sup>

71. This rulemaking could impose additional burdens on small entities. We considered alternatives to the rulemaking changes that increase projected reporting, recordkeeping and other compliance requirements for small entities.

**1. Alternatives Considered and Rejected**

72. *Urban and Rural Rates Under the Telecom Program.* The Administrator is the best entity to make publicly available a standardized set of urban and rural rates for use with all Telecom Program applications. Although we could obtain this information from rural health care providers or service providers, the Administrator is in the best position as a single expert entity to establish a publicly accessible urban and rural rate database and will greatly lessen the administrative burden on rural health care providers and their service providers.

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<sup>203</sup> 47 CFR §54.609(d) (2018).

<sup>204</sup> 5 U.S.C. § 603(c).



**G. Report to Congress:**

73. The Commission will send a copy of the Report and Order, including this FRFA, in a report to be sent to Congress and the Government Accountability Office pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996.<sup>205</sup> In addition, the Commission will send a copy of the Report and Order, including the FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the Report and Order and FRFA (or summaries thereof) will also be published in the Federal Register.<sup>206</sup>

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<sup>205</sup> 5 U.S.C. § 801(a)(1)(A).

<sup>206</sup> *See id.* § 604(b).

## APPENDIX C

**2017 Promoting Telehealth Notice and Order  
Comments and Reply Comments  
FCC 17-164**

<i>Commenter</i>	<u><i>Comments</i></u>	<i>Abbreviation</i>	<i>Date Filed</i>
Florida Big Bend Rural Health Network		FL Big Bend RHN	Jan. 16, 2018
Sitka Counseling		Sitka	Jan. 26, 2018
OCHIN and The California Telehealth Network		OCHIN/CTN	Jan. 29, 2018
Western New York Rural Broadband Healthcare Network		WNY RBHN	Jan. 29, 2018
Bristol Bay Area Health Corporation		BBAHC	Jan. 29, 2018
American Academy of Dermatology Association		AADA	Jan. 30, 2018
Illinois Rural HealthNet		IRHN	Jan. 31, 2018
Lumos Networks, Inc.		Lumos	Jan. 31, 2018
American Academy of Family Physicians		AAFP	Jan. 31, 2018
American Association of Nurse Anesthetists		AANA	Jan. 31, 2018
Peninsula Community Health Services of Alaska		PCHS	Jan. 31, 2018
Southcentral Foundation		SCF	Jan. 31, 2018
Federation of American Hospitals		FAH	Feb. 1, 2018
National Council for Behavioral Health		National Council	Feb. 1, 2018
Norton Sound Health Corporation		NSHC	Feb. 1, 2018
Council of Athabascan Tribal Governments		CATG	Feb. 1, 2018
American Telemedicine Association		ATA	Feb. 1, 2018
Alaska Native Tribal Health Consortium		ANTHC	Feb. 1, 2018
Community Hospital Corporation		CHC	Feb. 1, 2018
National Rural Health Association		NRHA	Feb. 2, 2018
California Hospital Association		CHA	Feb. 2, 2018
NTCA – The Rural Broadband Association		NCTA	Feb. 2, 2018
Christus Health		CHRISTUS	Feb. 2, 2018
National Judicial Opioid Task Force		NJOTF	Feb. 2, 2018
Florida Association of Community Health Centers, Inc.		FACHC	Feb. 2, 2018
AK Child & Family		AK Child	Feb. 2, 2018
Critical Access Hospital Coalition		CAH Coalition	Feb. 2, 2018
Connected Health Initiative		CHI	Feb. 2, 2018
Bristol Bay Area Health Corporation		BBAHC	Feb. 2, 2018
National Organization of State Offices of Rural Health		NOSORH	Feb. 2, 2018
American Association of Nurse Practitioners		AANP	Feb. 2, 2018
United States Telecom Association		USTelecom	Feb. 2, 2018
Health IT Now		HITN	Feb. 2, 2018
Alaska Tribal Administration Association		ATAA	Feb. 2, 2018
National Health Law Program and Center for Rural Strategies		NheLP/CRS	Feb. 2, 2018
New England Telehealth Consortium		NETC	Feb. 2, 2018
Dahl Memorial Clinic		DMC	Feb. 2, 2018
Alaska State Hospital & Nursing Home Association		ASHNHA	Feb. 2, 2018
Bartlett Regional Hospital		Bartlett Regional	Feb. 2, 2018
Maniilaq Association		Maniilaq	Feb. 2, 2018
The Rural Policy Research Institute Health Panel		RUPRI	Feb. 2, 2018
General Communication, Inc.		GCI	Feb. 2, 2018
TeleQuality Communications, LLC		TeleQuality	Feb. 2, 2018

Satellite Industry Association	SIA	Feb. 2, 2018
Schools, Health & Libraries Broadband (SHLB) Coalition	SHLB	Feb. 2, 2018
South Peninsula Hospital	SPH	Feb. 2, 2018
ADTRAN, Inc.	ADTRAN	Feb. 2, 2018
National Association of Community Health Centers	NACHC	Feb. 2, 2018
USF Consultants	USF Consultants	Feb. 2, 2018
Healthcare Information and Management Systems	HIMSS/PCHA	Feb. 2, 2018
Society and Personal Connected Health Alliance		
American Hospital Association	AHA	Feb. 2, 2018
NCTA – The Internet & Television Association	NCTA	Feb. 2, 2018
Yukon-Kuskokwim Health Corporation	YKHC	Feb. 2, 2018
Ninilchik Traditional Council	Ninilchik	Feb. 2, 2018
Chugachmiut	Chugachmiut	Feb. 2, 2018
College of Healthcare Information Management Executives	CHIME	Feb. 2, 2018
Franciscan Alliance Inc. and	Franciscan Alliance	Feb. 2, 2018
Parkview Health System, Inc.	& Parkview Health	
Space Exploration Technologies Corporation	SpaceX	Feb. 2, 2018
Central Peninsula Hospital	CPH	Feb. 2, 2018
Kellogg & Sovereign Consulting, LLC	KSLLC	Feb. 2, 2018
Alaska Communications Systems Group, Inc.	ACS	Feb. 2, 2018
Cross Road Health Ministries, Inc.	CRHM	Feb. 2, 2018
ADS Advanced Data Services, Inc.	ADS	Feb. 2, 2018
Alaska Primary Care Association	APCA	Feb. 2, 2018
Kenaitze Indian Tribe	Kenaitze	Feb. 2, 2018
Community Connections, Inc.	Community Connect	Feb. 2, 2018
Alaska Native Health Board	ANHB	Feb. 2, 2018
Kodiak Area Native Association	KANA	Feb. 2, 2018

**Reply Comments**

<i>Commenter</i>	<i>Abbreviation</i>	<i>Date Filed</i>
Western New York Rural Area Health Education Center, Inc.	WNY R-AHEC	Feb. 7, 2018
American Academy of Orthopaedic Surgeons	AAOS	Feb. 8, 2018
California Primary Care Association	CPCA	Feb. 8, 2018
Rural Hospital Coalition	RH Coalition	Feb. 13, 2018
Oregon Broadband Advisory Council	OBAC	Feb. 20, 2018
Bi-State Primary Care Association	BSPCA	Feb. 22, 2018
Texas Association of Community Health Centers	TACHC	Mar. 1, 2018
Southern Ohio Health Care Network	SOHCN	Mar. 5, 2018
Yukon-Kuskokwim Health Corporation	YKHC	Mar. 5, 2018
INCOMPAS	INCOMPAS	Mar. 5, 2018
General Communication, Inc.	GCI	Mar. 5, 2018
AT&T Services, Inc.	AT&T	Mar. 5, 2018
New England Telehealth Consortium	NETC	Mar. 5, 2018
ADS Advanced Data Services, Inc.	ADS	Mar. 5, 2018
TeleQuality Communications, LLC	TeleQuality	Mar. 5, 2018
Charter Communications, Inc.	Charter	Mar. 5, 2018
Alaska Communications Systems Group, Inc.	ACS	Mar. 5, 2018
Kellogg & Sovereign Consulting, LLC	KSLLC	Mar. 5, 2018
Schools, Health & Libraries Broadband (SHLB) Coalition	SHLB	Mar. 5, 2018
I'SOT, Inc. DBA Canby Family Practice Clinic	Canby Clinic	Mar. 6, 2018

**2017 Promoting Telehealth Notice and Order Refresh PN  
Comments and Reply Comments  
DA 18-1226**

**Comments**

<b><i>Commenter</i></b>	<b><i>Abbreviation</i></b>	<b><i>Filed</i></b>
Utah Education and Telehealth Network	UETN	Jan. 25, 2019
TeleQuality Communications, LLC	TeleQuality	Jan. 30, 2019
GCI Communications Corp.	GCI	Jan. 30, 2019
Alaska Communications Systems Group, Inc.	ACS Jan. 30, 2019	
AT&T Services Inc.	AT&T	Jan. 30, 2019
Schools, Health & Libraries Broadband Coalition	SHLB	Jan. 30, 2019

**Reply Comments**

<b><i>Commenter</i></b>	<b><i>Abbreviation</i></b>	<b><i>Filed</i></b>
GCI Communication Corp.	GCI	Feb. 13, 2019
Southcentral Foundation	SCF	Feb. 13, 2019
Alaska Communications Systems Group, Inc.	ACS Feb. 13, 2019	
Schools, Health & Libraries Broadband Coalition	SHLB	Feb. 13, 2019
NCTA – The Internet & Television Association	NCTA	Feb. 14, 2019
Alaska Radiology Associates	ARA	Feb. 14, 2019
Aleutians East Borough	AEB	Mar. 8, 2019
Alaska State Hospital and Nursing Home Association	ASHNHA	Mar. 18, 2019

**Ex Parte Letters and Other Filings (Post Comment Periods)**

<b><i>Filer</i></b>	<b><i>Abbreviation</i></b>	<b><i>Date Filed</i></b>
AT&T Services, Inc.	AT&T	Jan. 25, 2018
Alaska Communications Systems Group, Inc.	ACS	Jan. 29, 2018
American Hospital Association	AHA/ASHE	Feb. 8, 2018
Society for Healthcare Engineering of the AHA		
Enterprise Wireless Alliance	EWA	Feb. 13, 2018
Palmetto Care Connections	PCC	Mar. 2, 2018
GE Healthcare	GEHC	Mar. 27, 2018
The Evangelical Lutheran Good Samaritan Society	ELGSS	Mar. 30, 2018
Schools, Health & Libraries Broadband Coalition	SHLB	Apr. 3, 2018
Community Care of West Virginia	CCWV	Apr. 4, 2018
Schools, Health & Libraries Broadband Coalition	SHLB	Apr. 6, 2018
Peninsula Community Health Service of Alaska	PCHSA	Apr. 11, 2018
Southeast Health District	SHD	Apr. 11, 2018
Schools, Health & Libraries Broadband Coalition	SHLB	Apr. 12, 2018
Ninilchik Traditional Council Comm. Clinic	Ninilchick	Apr. 13, 2018
Akeela, Inc.	Akeela	Apr. 14, 2018
Central Peninsula Hospital	CPH	Apr. 15, 2018
North Carolina Telehealth Network	NCTN	Apr. 16, 2018
Alaska State Hosp. & Nursing Home Association	ASHNHA	Apr. 16, 2018

Council of Athabascan Tribal Governments	CATG	Apr. 17, 2018
Midcontinent Communications	Midcontinent	Apr. 19, 2018
Maniilaq Association	Maniilaq	Apr. 19, 2018
The Quilt	Quilt	Apr. 20, 2018
Bristol Bay Area Health Corp.	BBAHC	Apr. 20, 2018
Sitka Counseling	Sitka	Apr. 20, 2018
American Hospital Association	AHA	Apr. 24, 2018
Aleutians East Borough, AK	Aleutians	Apr. 24, 2018
City of Unalaska, AK	City of Unalaska	Apr. 26, 2018
City of Akutan, AK	City of Akutan	Apr. 27, 2018
University of Texas Health Science Center	UTHSC	Apr. 30, 2018
National Assoc. of Comm. Health Centers	NACHC	May 2, 2018
Schools, Health & Libraries Broadband Coalition	SHLB	May 3, 2018
Office of the Mayor, King Cove, AK	OMKC	May 3, 2018
PATHS Community Medical Center	PATHS	May 3, 2018
Highland Medical Center	HighlandMC	May 3, 2018
Chambers County Public Hospital District #1	CCPHD	May 3, 2018
California Hospital Association	CHA	May 4, 2018
Horizon Health Care, Inc.	Horizon	May 4, 2018
Tennessee Primary Care Association	TPCA	May 4, 2018
Yakima Neighborhood Health Services	Yakima	May 5, 2018
Canyonlands Healthcare	Canyonlands	May 7, 2018
Valle del Sol Community Health	Valle del Sol	May 8, 2018
El Rio Health Center	El Rio HC	May 8, 2018
Central Virginia Health Services, Inc.	CentralVA	May 8, 2018
Canby Family Practice Clinic	Canby	May 9, 2018
Tri-Area Community Health	Tri-Area	May 9, 2018
California Primary Care Association	CPPA	May 10, 2018
Mountain Valley Health Centers	MVHC	May 10, 2018
Virginia Community Health Association	VCHA	May 10, 2018
Shasta Cascade Health Centers	Shasta HC	May 14, 2018
Western Sierra Medical Clinic	Western Sierra	May 16, 2018
Bi-State Primary Care Association	BSPCA	May 25, 2018
American Hospital Association	AHA/KHA	June 1, 2018
Kansas Hospital Association		
Alaska Communications Systems Group, Inc.	ACS	June 6, 2018
AT&T Services, Inc.	AT&T	June 20, 2018
National Consumer Law Center	NCLC	July 5, 2018
Alaska Communications Systems Group, Inc.	ACS	Oct. 4, 2018
New England Telehealth Consortium	NETC/CTC	Oct. 16, 2018
Connections Telehealth Consortium		
Southern Ohio Health Care Network	SOHCN	Oct. 17, 2018
TeleQuality Communications, LLC	TeleQuality	Oct. 24, 2018
The App Association	App Association	Nov. 9, 2018
Schools, Health & Libraries Broadband Coalition	SHLB/NETC/CTN/OBN	Nov. 27, 2018
New England Telehealth Consortium		
California Telehealth Network		
OCHIN Broadband Network Services		
Alaska Communications Systems Group, Inc.	ACS	Dec. 17, 2018
Alaska Communications Systems Group, Inc.	ACS	Feb. 4, 2019
Cambell Killin Brittan & Ray, LLC	Cambell	Feb. 20, 2019
American Cable Association	ACA	Feb. 28, 2019



GCI Communications Corp.	GCI	Mar. 1, 2019
Schools, Health & Libraries Broadband Coalition	SHLB	Mar. 15, 2019
GCI Communications Corp.	GCI (OEA 1)	Mar. 20, 2019
GCI Communications Corp.	GCI (OEA 2)	Mar. 20, 2019
GCI Communications Corp.	GCI (Comm'r. O)	Mar. 20, 2019
GCI Communications Corp.	GCI (Comm'rs. S/C)	Mar. 20, 2019
Alaska Communications Systems Group, Inc.	ACS	Mar. 28, 2019
Schools, Health & Libraries Broadband Coalition	SHLB/NETC/CTC/CHI	Apr. 2, 2019
New England Telehealth Consortium		
Connections Telehealth Consortium		
Catholic Health Initiatives		
New England Telehealth Consortium	NETC/CTC	Apr. 9, 2019
Connections Telehealth Consortium		
New England Telehealth Consortium	NETC/CTC/HCN	Apr. 25, 2019
Connections Telehealth Consortium		
HealthConnect Networks		
Alaska Communications Systems Group, Inc.	ACS	May 2, 2019
Altru Regional Telehealth Network	ARTN	May 6, 2019
Geisinger Health Systems	GHS	May 7, 2019
New England Telehealth Consortium	NETC/CTC/HCN	May 8, 2019
Connections Telehealth Consortium		
HealthConnect Networks		
Schools, Health & Libraries Broadband Coalition	SHLB	May 15, 2019
GCI Communications Corp.	GCI (Brattle)	May 24, 2019
Alaska Communications Systems Group, Inc.	ACS	May 28, 2019
Alaska Native Village Corporation Association	ANVCA	May 28, 2019
GCI Communications Corp.	GCI	May 30, 2019
Community Hospital Corporation	CHC	June 17, 2019
TeleQuality Communications, LLC	TeleQuality/ENA	June 18, 2019
Electronic Networks of America		
Quintillion Subsea Operations, LLC	QSO	June 19, 2019
Alaska Communications Systems Group, Inc.	ACS et al.	June 20, 2019
Cameron Law & Policy, LLC		
Quintillion Subsea Operations, LLC	QSO	July 8, 2019
Schools, Health & Libraries Broadband Coalition	SHLB	July 15, 2019
American Hospital Association	AHA/KHA	July 16, 2019
Kansas Hospital Association		
GCI Communications Corp.	GCI	July 17, 2019
GCI Communications Corp.	GCI	July 18, 2019
TeleQuality Communications, LLC	TeleQuality	July 18, 2019
Community Care of West Virginia, Inc.	CCWV	July 19, 2019
Alaska Communications Systems Group, Inc.	ACS	July 19, 2019
Sitka Counseling	Sitka	July 22, 2019
Schools, Health & Libraries Broadband Coalition	SHLB	July 22, 2019
Colorado Hospital Association	CHA	July 22, 2019
Maniilaq Association	Maniilaq	July 22, 2019
Bristol Bay Area Health Corporation	BBAHC	July 22, 2019
Aleutian Pribilof Islands Association	API Assoc.	July 23, 2019
Council of Athabascan Tribal Governments	CATG	July 23, 2019
Alaska Native Tribal Health Consortium	ANTHC	July 23, 2019
Ninilchik Traditional Council Comm. Clinic	Ninilchik	July 23, 2019
Alaska State Hospital and Nursing Home Association	ASHNHA	July 23, 2019

Southern Ohio Health Care Network	SOHCN	July 23, 2019
GCI Communication Corp.	GCI	July 23, 2019
Eastern Aleutian Tribes	Eastern Aleutian Tribes	July 24, 2019
GCI Communications Corp.	GCI	July 24, 2019
Chugachmiut	Chugachmiut	July 24, 2019
Alaska State Hospital and Nursing Home Association	ASHNHA	July 24, 2019
National Rural Health Association	NRHA	July 24, 2019
Alaska Communications Systems Group, Inc.	ACS	July 24, 2019
Alaska Native Health Board	ANHB	July 24, 2019
Alaska Primary Care Association	Alaska Primary Care	July 25, 2019
USTelecom – The Broadband Association	USTelecom	July 25, 2019
Schools, Health & Libraries Broadband Coalition	SHLB	July 25, 2019
ADS – Advanced Data Services, Inc.	ADS	July 25, 2019
GCI Communications Corp.	GCI (First)	July 25, 2019
GCI Communications Corp.	GCI (Second)	July 25, 2019
Kodiak Area Native Association	KANA	July 25, 2019
Yukon-Kuskokwim Health Corporation	YKHC	July 25, 2019
Alaska Native Tribal Health Consortium	ANTHC	July 25, 2019
Alaska Communications Systems Group, Inc.	ACS	July 25, 2019
Alaska Communications Systems Group, Inc.	ACS (Erratum)	July 25, 2019
Peninsula Community Health Services of Alaska	PCHS	July 25, 2019
GCI Communications Corp.	GCI	July 26, 2019
North Carolina Telehealth Network Association	NCTN	July 26, 2019
Southcentral Foundation	SCF	July 29, 2019
GCI Communications Corp.	GCI (Reply)	July 29, 2019
GCI Communications Corp.	GCI	July 30, 2019
GCI Communications Corp.	GCI	July 31, 2019

**STATEMENT OF  
CHAIRMAN AJIT PAI**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

In my time here, I've been known to mention the fact that I was raised in rural Kansas. But my father's story is more relevant here than any other anecdote I could share. When I was growing up, my dad was one of the only urologists for miles around and made countless trips throughout southeast Kansas to make sure patients in communities without specialists like him could see one when they needed one. However, in recent years it has become harder for small towns to recruit and retain specialists. And to add to the problem, many rural hospitals are struggling just to keep the doors open.

So it's hard to overstate the value that telemedicine can add to our health care system. These transformative technologies are helping to bring advanced health care to rural areas across the country. Whether it's transmitting electronic medical records, real-time medical imaging, videoconferencing with remote doctors, or enabling specialists to remotely monitor patients in rural hospitals and clinics, connectivity between patients and health care providers is essential to the one in five Americans who live in rural areas. Indeed, to give just one recent example of what is possible, primary care doctors now can use a connected retinal camera during office visits to catch diabetic retinopathy, the leading cause of blindness among people with diabetes, with the help of a remote ophthalmologist.

I've had the privilege of seeing telemedicine's potential in many parts of the country. I've visited the Cleveland Clinic in Ohio and Ochsner Health System in Louisiana; Christiana Care in Delaware and the Children's Hospital of Philadelphia; the Packard Children's Hospital in California and the University of Kansas Medical Center; St. Mary's Medical Center in Colorado and the Moab Regional Hospital in Utah. And I've been to many Veterans Affairs facilities, like the Lecanto Community Based Outpatient Clinic in Lecanto, Florida; the National Tele-Mental Health Hub in Salt Lake City, Utah; the Tele-Seizure Program in Providence, Rhode Island; and the VA Medical Center in Boise, Idaho. Every one of these visits inspires me and underscores the importance of making these success stories the norm around the country. The FCC's Rural Health Care Program is our primary way to do that.

In recent years, program demand has begun surpassing available funding. So in December 2017, I proposed and the Commission began this rulemaking to increase the annual funding cap and promote greater efficiency and cost-effectiveness in the program.

Last year, and for the first time in the agency's history, the FCC increased the funding cap—by more than 40%. This was a necessary change, but not a sufficient one to guarantee the program's long-term health. We also need to do more to root out waste, fraud, and abuse in the program, for every dollar misspent is a dollar not devoted to telemedicine and the patients who need it.

So today, we are taking steps to ensure that every dollar in the program is being spent efficiently. These measures will promote transparency, accountability, and predictability in the Rural Health Care Program. This Order will replace guesswork with certainty for rural health care providers. They will have greater insight into the amount of support available for requested services. They will receive funding decisions more quickly so that they can focus on delivering cutting-edge health care to their patients. And these reforms will also reduce waste by ending communications service providers' ability to manipulate the calculation of rates for their own benefit.

For this last reason, I understand that some service providers are unhappy about some of the steps taken in this Order. But the purpose of this program isn't to pad their bottom line; it's to make it easier and cheaper for health care providers to treat their patients. This is the Rural Health Care Program, and this FCC is going to continue to do what is necessary and appropriate to ensure that connectivity helps make Americans healthier and communities stronger.

I'd like to thank the talented staff that put so much time and effort into today's item, including: Allison Baker, Phil Bonomo, Regina Brown, Liz Drogula, Darren Fernandez, Trent Harkrader, Billy

Layton, Kris Monteith, Ryan Palmer, Johnnay Schrieber, and Joe Sorresso from the Wireline Competition Bureau; Octavian Carare, Eric Ralph, Emily Talaga, Shane Taylor, and Tracy Waldon from the Office of Economics and Analytics; and Malena Barzilai, Valerie Hill, Rick Mallen, Linda Oliver, and Bill Richardson from the Office of General Counsel.

**STATEMENT OF  
COMMISSIONER MICHAEL O'RIELLY**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

At the outset, the Telecom Program arm of the Rural Health Care program has played a valuable role in improving access to health services in some of the most remote parts of our country, and I am firmly committed to protecting its viability, per our statutory requirement. Due to circumstances that predate this Commission, vague rules and inefficiencies have plagued the program, and the need for a systematic overhaul has become evident. I therefore commend the Chairman, staff, and stakeholders for coming up with a plan that will hopefully establish much better predictability and efficiency in the program. As in the case of the previous mapping item, I certainly have some concerns over USAC's ability to complete the seemingly-gargantuan task of developing urban and rural rate databases envisioned by the draft in time for Funding Year 2021—especially given all the other work we assign the Administrator today. Despite this, the item can potentially serve as a serious step in the right direction.

When the original draft circulated, I raised doubts about the applicability of the new tiered structure to a state like Alaska—so geographically vast and challenging that it truly exists in a category of its own. As I saw from my own visit to that state when I first joined the Commission, many villages are outside the road system and are accessible only by air or water and are in turn extremely complicated and expensive to serve. From the original draft's own map, it was clear that the vast majority of the state would fall into a single tier, creating problematic outcomes for the most isolated villages—both as a matter of policy and in view of our statutory duty to ensure access to rates that are reasonably comparable to those in urban areas of the state.

The Commission previously recognized the need for unique treatment of Alaska in numerous instances over the years, including in our High Cost program, and I believe it is crucial to carve out state-specific rules here as well. I thank the Chairman and staff for their work in adapting the tiered approach to the unique circumstances in Alaska and arriving at a reasonable and administratively feasible landing spot. I also appreciate that the Chairman agreed to strike the heightened waiver standard as initially proposed, should a strict application of the rules prove problematic in specific instances. Parties always have the right to petition the Commission under our existing standard, and it would not be fair to apply a more heightened standard—particularly one that imposes a task as burdensome as a cost study—in selective cases.

I am also thankful to the Chairman's office for agreeing to strike—at my behest—the decision to import a very problematic E-Rate rule into the Rural Health Care Program. While cost-effectiveness should no doubt drive the Commission's competitive bidding processes, the “price as the primary factor” rule has done a *terrible* job in selecting E-Rate projects that are *actually* cost-effective. To the extent that the rule is applied myopically within the confines of a singular bidding matrix, it completely fails to take into account whether a given project would be cost-effective for the USF as a whole. That has led to USAC permitting very wasteful overbuilds in the E-Rate program—often involving recipients of funding under the Commission's own High Cost program—and we should not import those problems over here. And, doing so would be especially inappropriate given an ongoing proceeding on changing the E-Rate rules to address the rule's role in enabling FCC-funded overbuilding. I therefore thank the Chairman for agreeing to remove that problematic section from the draft and look forward to addressing broader overbuilding issues in due course.

While I am hopeful that the new rules will inject much more predictability and efficiency into the program, I remain dismayed by our continued decision to fund urban applicants, even if the latter remain on the lowest rungs of priority when demand exceeds available funding. I was not on the Commission when it originally decided in 2012 to allow urban provider participation, and while I am well-aware of the policy arguments that have been made in favor of that decision, the bottom line remains that our statutory mandate under section 254(h) is restricted to health care providers in *rural* areas. While phasing out the three-year grace period for majority-rural participation in consortia is a positive step, I hope that our next

action with respect to this program will be to remove urban funding altogether. Absent Congress changing the law, the money now allocated for urban providers could be used to fund a lot of good in needy rural areas.

On a related and final note, I think it is important to recognize that the application of this item is on a prospective basis, with the rate database not going into effect until Funding Year 2021. Indeed, when the Commission recognizes that its rules are not meeting expectations, it makes all the sense in the world to modify a program on a going-forward basis. However, this principle also raises questions regarding efforts to retroactively alter payments previously committed to providers under rules that we acknowledge today are vague and unclear. At some point, the Commission is expected to act on a petition to reconsider those recent decisions, and as such, based on the information I have seen so far and the many meetings I have conducted, I have significant concerns regarding our decisions so far.

For the reasons mentioned, I will support the item.



**STATEMENT OF  
COMMISSIONER BRENDAN CARR**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

Healthcare is moving closer to patients. We recognized this revolution in care last month, when we advanced my proposal to establish the Connected Care Pilot Program. The idea is that by using the latest in-home technology, patients can get more frequent and more affordable care. Health professionals can check up more regularly on patients—especially those with chronic illnesses—and can prevent sickness from getting out of control and resulting in expensive hospital stays. I’ve seen firsthand how telehealth can improve outcomes and reduce costs in addressing diabetes in Mississippi, stroke response in South Carolina, and pain management in West Virginia. Trials by the Veterans Health Administration, among others, give us hope that reliable Internet connections at home can improve Americans’ health.

The challenge we meet in today’s Order is related. It’s the challenge of connecting rural healthcare facilities. They’re the vital link between in-home care and hub hospitals, and they’re where most care happens in rural America. One such facility is in the small town of Lennox, South Dakota, which is surrounded by farmland in the state’s Eastern plains. I visited last year to see for myself how the Internet can power rural care. Lennox’s skilled nursing facility has a connected work station that they call “Johnny 5.” Through a broadband connection, Johnny 5 allows Lennox patients to visit virtually with a doctor in Sioux Falls—or anywhere else. The technology is especially impactful for nursing home patients who often require specialists who just can’t afford to be in Lennox full-time. And virtual visits spare elderly patients the uncomfortable and costly rides in an ambulance between facilities.

The Commission’s telehealth program funds broadband connections to Johnny 5 and other vital technology in rural clinics. But in the past few years, the Rural Healthcare Program has come under some strain. Demand for Rural Healthcare Program funds has exceeded the program’s budget for the first time. And this has resulted in inconsistency and lack of predictability for both healthcare and broadband providers alike.

So the Order adopts a number of reforms that seek to prioritize funding and make the program more efficient. I want to focus on one in particular and thank my colleagues for agreeing to include the reform in our decision today. In previous years, the deadline for applying for program funding has been set too close to the start of the program year. In many cases, this did not give the FCC or program participants enough time to address outstanding issues. So the program year would start and providers would not know whether they would be reimbursed. To reduce the likelihood that we see this type of uncertainty, I asked my colleagues to move up the deadline for applications so that USAC could have 90 days before the start of a program year to process applications. The goal is to provide as accurate a funding number as possible before the private sector starts incurring expenses. This certainty should provide additional stability to the program and lessen the need for across-the-board cuts once the program year has started.

I thank my colleagues for their support of this edit, and I would like to thank the Wireline Competition Bureau for its work on the item. It has my support.

**STATEMENT OF  
COMMISSIONER JESSICA ROSENWORCEL,  
APPROVING IN PART, DISSENTING IN PART**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

I have seen rural clinics in Montana that use their connectivity to exchange electronic medical records on both sides of the continental divide. I have watched as pediatric surgeons in California share their expertise via video with patients many miles away. I have witnessed village clinics in rural Alaska use broadband to provide first-class care to patients in some of this country's most remote communities. These experiences amaze because they can challenge our traditional notions of healthcare. They make clear that telemedicine can collapse distance and time and enhance the quality of care while also improving outcomes and lowering costs.

This is why the Rural Health Care Program is so important. It uses the power of communications to bridge vast distances and help bring care to places where it is most needed. Of course, when this program got its start two decades ago, neither communications nor medicine looked much like they do today. Virtual reality, prescription vending machines controlled by doctors at a distance, and electronic health records were the stuff of science fiction. But today, they've become standard medical training and practice.

So a year and a half ago, the Federal Communications Commission embarked on an effort to update this program. Along the way, we raised the program cap to keep up with new demand. Today, the agency finishes that update. We make improvements to program administration. For instance, we codify a gift rule to guard against graft. We also clarify program procedures, provide additional time for applicants to conduct competitive bidding, extend service delivery deadlines, and make program data more accessible. These are smart changes. They have my support.

But in other respects, this decision falls short. It puts in place a new funding scheme for the Telecommunications Program that has never been tested, modeled, or assessed for its impact on the rural health facilities that rely on the program today. This creates a truckload of uncertainty for rural America. That's not fair, so on this aspect of the decision, I dissent.

The Telecommunications Program is the very first program the FCC developed for rural healthcare support. The demand for its resources now makes up about half of the more than \$500 million provided in assistance annually under the entire Rural Health Care Program. It is the program relied on by the most rural and remote healthcare facilities in this country. By statute, the agency provides support to rural healthcare providers for the difference between the rates they are charged and those for comparable services in urban areas. Over the years, as a result of policy changes and advancements in technology, it has become more difficult to perform this calculation.

In response, today the FCC creates a new funding regime based on the median rates for services in a mix of rural and urban areas in each state. This is complex, so it is hard to unpack the consequences. But for starters, limiting support based on median rates could very easily cut off the most far-flung health facilities in remote locations that depend on these funds for operation. Plus, the map the FCC offered to explain its tiers for rural rates is not all illuminating. It offers no detail, is not searchable and it originally omitted one state entirely. On top of this, late last night, the agency added another tier to its mix of state urban and rural areas, making it even harder to understand the real consequences on the ground.

I think a data-driven agency should offer some data about the impact of these changes. I think we should model how it will change the support this program provides to health care operations in some of our most remote areas. We have not done so. Because there is no model, we don't know how this will reduce the support available to some rural communities. Without a model, we don't know how these changes could cut off rural health care in Alaska, Texas, Wisconsin, Mississippi, North Dakota and many more places. Furthermore, I am concerned about the extent to which this agency puts this new regime in the hands of our program administrator.

It would be cruel if as a result of our tinkering in Washington we shutter health care operations in some of our most remote communities. It didn't have to be like this. There was a way to fix these problems. There was a way to address this uncertainty. These portions of today's order should be put out for rulemaking and comment. This would give us time to model the impact of these changes before unleashing consequences on the patients who rely on this program for basic healthcare. It would give us time to get it right. This is why a bipartisan group of 15 Senators—Senators Wyden, Hoeven, Udall, Cornyn, Capito, Baldwin, Brown, Murkowski, Cramer, Bennet, King, Heinrich, Manchin, Collins, and Sullivan—urged us to fix this situation before any healthcare facilities are forced to close in rural areas. But I regret that is not what we do today.

**STATEMENT OF  
COMMISSIONER GEOFFREY STARKS  
APPROVING IN PART AND DISSENTING IN PART**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

I am a big believer in the power and potential for telehealth to save lives, improve care, and transform the way people interact with doctors and health care systems. I come from a family of doctors and I know what a difference that having the right care and monitoring options available at the right time can make to patients and their families. I've seen first-hand the difference that telehealth can make while visiting with Corie Nieto, the director of telehealth services at the Nevada Health Center Clinic in Amargosa Valley, Nevada. This clinic is in a rural community where telehealth technology connects distant doctors with patients, bringing expertise and specialty services that would otherwise be unavailable into the community. I learned, during a recent visit to Winston Salem State University in North Carolina, about LliBott Consultorios Médicos, a group of four primary care clinics focused on serving North Carolina's Latino community, including through telemedicine visits. I've also seen how the Veteran's Administration is using telemedicine to have distant specialists diagnose stroke victims and provide medicines quickly, during the critical time period in which they can make a life-saving difference.

The Commission's Rural Health Care program provides essential support to programs like these. It allows rural health care providers to acquire the high-speed internet connectivity they need to bring services to rural America at the same rates that their urban counterparts pay. It provides essential support for networks linking rural and urban healthcare providers. And, the Rural Health Care program isn't just a good idea that is changing and saving lives, it's a program that the FCC carries out to meet its obligations under the law.

The order that the Commission is adopting today makes changes to the Rural Health Care program with the stated intent of "reforming the program to promote transparency and predictability, and to further the efficient allocation of limited program resources." These are laudable goals, as I firmly believe that all of the Commission's Universal Service programs should be run in a transparent and efficient manner and should be predictable for program participants and beneficiaries. And, some of the changes the order makes are common sense improvements that I support. However, some of the decisions in the order, particularly the adoption of a new method for determining levels of support in the Telecommunications program, will have a profound impact on program participants and on people who depend on telehealth that the Rural Health Care program makes available.

The order does not describe or analyze the expected impact of these changes for health care providers or for the telecommunications providers who provide service to them. I have similar concerns about portions of the order that create a new system of prioritizing support requests and that adopt new rules for healthcare consortia members. For these reasons, I supported my colleague Commissioner Rosenworcel's request to move parts of the Order into a further notice. Doing so would have allowed the Commission to develop additional information in the record, to learn about the potential impacts of its proposed changes, and to devise solutions to address these impacts. This request was ultimately not accepted and, accordingly, I am dissenting from these portions of the order.

I am not alone in wanting the Commission to take more time and conduct more analysis before adopting this order. Just yesterday, the entire Alaska Congressional delegation sent a letter to the Commission cautioning against "hasty adoption" of an order that contains "numerous prospects for unintended consequences that undermine the stability and sustainability of the program."<sup>1</sup> We received

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<sup>1</sup> See Letter from Senators Lisa Murkowski and Dan Sullivan and Congressman Don Young to FCC Chairman Ajit Pai, July 31, 2019,

(continued....)

other letters this week from a bipartisan group of 14 U.S. Senators asking for the Commission to postpone adoption of this order.<sup>2</sup> One of these letters notes that the Order “fails to provide sufficient guardrails of transparency to guarantee confidence that the program will be implemented in a consistent manner.”

I believe that this order, with its shortfalls in consideration of the impact of many of its proposals, is symptomatic of a larger concern of mine that I have consistently voiced - we aren’t doing a good enough job gathering and using data to make decisions and solve problems. For example, one of the major components addressed in today’s order (and also addressed in the letters received from Congress), is how to determine which urban and rural rates to compare in order to establish support levels. This is essentially a data problem, where better information about the problem the Commission is trying to solve would lead to better decisions. I believe that in this case, and in any instance where the Commission faces complex policy choices, it needs to make sure that it has the data necessary to fully understand the problem, the policy options, and the impacts they will have. Only then can it create effective, data driven policy solutions.

However, I do support portions of the order which make changes to the competitive bidding process, to program administration, and to the program’s application processes. I view these changes as good governance measures that improve the overall program.

I thank the staff of the Wireline Competition Bureau for their hard work on this Order and for their ongoing efforts to make the Rural Health Care Program a success in bringing health care and the benefits of telehealth to those in the U.S. who need them the most.

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[https://www.sullivan.senate.gov/imo/media/doc/20190731\\_Alaska%20delegation%20letter%20to%20FCC%20re%20RHC.pdf](https://www.sullivan.senate.gov/imo/media/doc/20190731_Alaska%20delegation%20letter%20to%20FCC%20re%20RHC.pdf).

<sup>2</sup> See Letter from Senators Ron Wyden, John Hoeven, Tom Udall, John Cornyn, Shelly Moore Capito, Tammy Baldwin, Sherrod Brown, Lisa Murkowski, Kevin Cramer, Michael F. Bennet, Angus S. King, Jr., Martin Heinrich, and Joe Manchin III to FCC Chairman Ajit Pai, July 30, 2019. <https://www.wyden.senate.gov/imo/media/doc/073019%20FCC%20RHCP%20Letter.pdf>; Letter from Senator Susan Collins to FCC Chairman Ajit Pai, July 31, 2019.